

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Hocklander

12380

12402

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		LENGTH OF STAY (In this place) <u>2 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>111 1/2 West Franklin St.</u>			
3. NAME OF DECEASED (Type or Print) <u>HARRY HILTON ALLEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 14 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 7 1916</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Robert Allen</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-6659</u>		17. INFORMANT & ADDRESS <u>Mrs Janice Allen</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
463X IMMEDIATE CAUSE (A) <u>Pulmonary embolus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thromb. phlebitis rt leg.</u>						<u>1 1/2</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/3/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Hepatic hernia</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>55</u> , and that death occurred at <u>2:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E Hocklander</u>				DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Hagerstown Wash. Co Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Dec. 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			

CERTIFICATE OF DEATH

Form 100-1-35

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. DATE OF BIRTH (Month, Day, Year)

5. OCCUPATION

6. CAUSE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. MARITAL STATUS

10. RACE

11. EDUCATION

12. RELIGION

13. SERVICE

14. MANNER OF DEATH

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF ARCHIVIST

BUREAU V. 2

DEC 20 1955

RECEIVED

PHOTOGRAPH

NOTES: This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. A copy of this certificate is to be sent to the local health officer of the county or city in which the death occurred. A copy of this certificate is also to be sent to the local health officer of the county or city in which the death occurred. A copy of this certificate is also to be sent to the local health officer of the county or city in which the death occurred.

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12381

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Hagerstown HOSPITAL OR INSTITUTION OR STREET ADDRESS Brook Lane Farm Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore City CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 12, Maryland STREET ADDRESS (If rural give location) 1504 Gleneagle Road	
3. NAME OF DECEASED (First) (Middle) (Last) Giltz C. Bauer		4. DATE OF DEATH (Month) (Day) (Year) Dec. 5 1955	
5. SEX M.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 11, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.	9. AGE last birthday 68 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George K. Bauer		14. MOTHER'S MAIDEN NAME Margaret Giltz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 216-10-3576	
17. INFORMANT & ADDRESS Mrs. Marie Bauer, 1504 Gleneagle Rd. Baltimore 12, Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 490x IMMEDIATE CAUSE (A) Lobar Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) General physical debility (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH Two days Five mos.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 13, 1955, to present, 1955, that I last saw the deceased alive on Nov. 29, 1955, and that death occurred at 10:30 A.M. from the causes and on the date stated above. SIGNATURE Helmut Trager M.D. 1308 Eutaw Place, Baltimore 17, Md. 12/5/55 ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/8/55	
NAME OF CEMETERY OR CREMATORY Western Cem.		LOCATION (City, town, or county) Balto., Md.	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Chas. H. Bowens		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Sicker & Sons - Balto. 17, Md.	

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12382

12465

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Hagerstown</u>		<u>2 years 9 mo.</u>		TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gateway Conv. Home</u>				STREET ADDRESS <u>915 Hamilton Blvd.</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>SUSAN</u>		(Middle) <u>ALICE</u>		(Last) <u>BECK</u>		<u>December 8 19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>July 12, 1864</u>	<u>91</u> yrs.	Months <u>4</u>	Days <u>26</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Hagerstown, Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Granville Wilson</u>				<u>Anna Norton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
			<u>none</u>		<u>William G. Beck Hagerstown, Maryland</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>February 20, 19 55</u>, to <u>Dec 8</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>Dec 3</u>, 19 <u>55</u>, and that death occurred at <u>5:30 PM</u>, from the causes and on the date stated above. <u>12/8/55</u>							
SIGNATURE <u>Robert Vh Campbell</u> M.D. <u>145 W Washington St Hagerstown Md</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/11/1955</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DATE <u>Dec 10, 1955</u></u>		<u>Chas H Bowers</u>		<u>C. M. Suter & Sons Hagerstown, Maryland</u>			

CERTIFICATE OF DEATH

REG. GEN. NO. 201

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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BUREAU V. S.

DEC 13 1955

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INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who attended the deceased during the last illness. It should be filled out as soon as possible after death, and before the body is moved or buried. It should be filled out in the presence of the family, if possible, and the signature of the physician or other qualified person should be witnessed by the family. The form should be filled out in the presence of the family, if possible, and the signature of the physician or other qualified person should be witnessed by the family. The form should be filled out in the presence of the family, if possible, and the signature of the physician or other qualified person should be witnessed by the family.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12383

12403 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL OR and give nearest town) HAGERSTOWN TOWN HAGERSTOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 434 S. POTOMAC ST.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN TOWN HAGERSTOWN STREET ADDRESS (If rural give location) 434 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or Print) (First) HALLIE (Middle) VIVIAN (Last) BESTER				4. DATE OF DEATH (Month) DEC. (Day) 25 (Year) 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, WIDOWED	8. DATE OF BIRTH 3/14/1882	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if HOUSEWIFE)		10b. KIND OF BUSINESS HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME THOMPSON SEIGMAN				14. MOTHER'S MAIDEN NAME ANNIE BENNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. CATHERINE HEFELFINFER HAGERSTOWN MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE(S) DUE TO arterio sclerotic myocardial heart disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO with myocardial failure grade Iv STATING UNDERLYING CAUSE LAST. (C) _____						5yrs 2yrs	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from Oct. 19 49 , to Dec. 25, 19 55 , that I last saw the deceased alive on Dec. 24, 19 55 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. SIGNATURE S. Robert Wells ADDRESS (Street, city, town, state) 115 N. Potomac St. Hagerstown, Md. 12-27-55 M.D. 115 N. Potomac St. Hagerstown, Md. 12-27-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/28/55		NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. REC'D BY REGISTRAR DATE Dec. 29, 1955		REGISTRAR'S SIGNATURE Shaff Powers		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md			

1254

1965-1966

BUREAU V. S.

RECEIVED

12404

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wash.		MARYLAND		STATE Md.		COUNTY Wash.	
CITY (If outside corporate limits, write RURAL OR TOWN) Hagerstown		LENGTH OF STAY (in this place) 23 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Garlock Nursing Home				STREET ADDRESS (If rural give location) 813 Mulberry Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) Corinna Lee Bew				4. DATE (Month) (Day) (Year) OF DEATH: Dec. 16 1955			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH: March 6, 1868	9. AGE last birthday: 87 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Gloucester Co., Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: James Pearce				14. MOTHER'S MAIDEN NAME: Mary Groom			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS: Raymond Bew, Hagerstown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE		(A) Ch. Myocarditis				10 yrs	
ANTECEDENT CAUSE (S):		(B) Scurvy				10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-10, 1955, to 12-16, 1955, that I last saw the deceased alive on Dec 15, 1955, and that death occurred at 2 M, from the causes and on the date stated above.							
SIGNATURE S. D. Webb		ADDRESS M. D. Hagerstown		DATE SIGNED 12-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-19-55		NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		LOCATION (City, town, or county) (State) Richmond, Va.	
DATE REC'D BY LOCAL REGISTRAR Dec 18, 1955		REGISTRAR'S SIGNATURE S. D. Webb		24. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 21 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12405

CERTIFICATE OF DEATH

Dr Kneisley

12385

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>3 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>120 So Prospect St</u>				STREET ADDRESS (If rural give location) <u>120 So. Prospect St</u>			
3. NAME OF DECEASED (Type or Print) <u>BERTHA</u> (First) <u>BETTIE</u> (Middle) <u>BOWERS</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 29 1955</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 29 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City-Treas Dittman Lumber Co</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Downin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-05-4983</u>		17. INFORMANT & ADDRESS <u>Mrs Delva Doub</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
584X IMMEDIATE CAUSE (A) <u>Acute suppurative cholangitis</u>						4 wks.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic cholecystitis with cholelithiasis</u>						5 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Moderate portal cirrhosis</u>						5 mo.	
19a. DATE OF OPERATION <u>July, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Chronic cholecystitis with cholelithiasis; portal cirrhosis</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 18, 1955</u> , to <u>Dec. 29, 1955</u> , that I last saw the deceased alive on <u>Dec. 29, 1955</u> , and that death occurred at <u>5:15P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>148 W. Washington St. Hagerstown, Md.</u>			
DATE SIGNED <u>Dec. 30, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/1/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Hagerstown Wash. Co Md</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. SEX

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF COURT

16. SIGNATURE OF STATE

17. SIGNATURE OF COUNTY

18. SIGNATURE OF CITY

19. SIGNATURE OF TOWNSHIP

20. SIGNATURE OF PARISH

21. SIGNATURE OF VILLAGE

22. SIGNATURE OF HAMLET

23. SIGNATURE OF CENSUS TRACT

24. SIGNATURE OF BLOCK

25. SIGNATURE OF HOUSEHOLD

26. SIGNATURE OF ROOM

27. SIGNATURE OF BED

28. SIGNATURE OF CHAIR

29. SIGNATURE OF TABLE

30. SIGNATURE OF CLOSET

31. SIGNATURE OF BATH

32. SIGNATURE OF KITCHEN

33. SIGNATURE OF LIVING ROOM

34. SIGNATURE OF DINING ROOM

35. SIGNATURE OF PORCH

36. SIGNATURE OF PATIO

37. SIGNATURE OF GARAGE

38. SIGNATURE OF DRIVE

39. SIGNATURE OF YARD

40. SIGNATURE OF GARDEN

41. SIGNATURE OF POOL

42. SIGNATURE OF FENCE

43. SIGNATURE OF WALK

44. SIGNATURE OF DRIVEWAY

45. SIGNATURE OF PORCH

46. SIGNATURE OF PATIO

47. SIGNATURE OF GARAGE

48. SIGNATURE OF DRIVE

49. SIGNATURE OF YARD

50. SIGNATURE OF GARDEN

51. SIGNATURE OF POOL

52. SIGNATURE OF FENCE

53. SIGNATURE OF WALK

54. SIGNATURE OF DRIVEWAY

55. SIGNATURE OF PORCH

56. SIGNATURE OF PATIO

57. SIGNATURE OF GARAGE

58. SIGNATURE OF DRIVE

59. SIGNATURE OF YARD

60. SIGNATURE OF GARDEN

BUREAU V. S.

JAN 5 1956

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT.

MARYLAND STATE DEPARTMENT OF HEALTH

12386

12466

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE W. Va. COUNTY Werkley	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rural Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Martinsburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hagerstown Md.		STREET ADDRESS (If rural, give location) Route 1	
3. NAME OF DECEASED (Type or Print) (First) Alice (Middle) - (Last) Bowman		4. DATE OF DEATH (Month) Dec. (Day) 11 (Year) 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1944
9. AGE last birthday 11 yrs.		10. If under 1 year 11 Months 11 Days 11 Hours 11 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Warren C. Bowman		14. MOTHER'S MAIDEN NAME Helen V. Hess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT AND ADDRESS Walter Hess - R# 1 Martinsburg, W. Va.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
816X Immediate cause (a) Fractured skull - closed fractured rt. femur Antecedent cause(s) (b) hemorrhage & shock Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) -		5 min.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none		
19a. DATE OF OPERATION -	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg, etc.) Highway	(CITY OR TOWN) Hagerstown (COUNTY) Rural- Wash (STATE) Md.
TIME (Month) (Day) (Year) (Hour) (Minute) Dec. 11 '55 7:10PM	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Auto- Truck Collision

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, or undetermined ☐.

SIGNATURE **S. Robin - Wells M.D.** ADDRESS **115 N. Potomac St - Hagerstown Md** DATE SIGNED **12-13-55**

23. RIAL CREMATION (Specify) **Burial** DATE THEREOF **12-15-55** NAME OF CEMETERY OR CREMATORY **Butlers Chapel** LOCATION (City, town, or county) **Martinsburg** (State) **W. Va**

DATE REC'D BY LOCAL REG. **Dec. 12, 1955** REGISTRAR'S SIGNATURE **Scott F. Minnich & Son Hag. Md.** 24. FUNERAL DIRECTOR ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1955

BUREAU V. S.

12387

MARYLAND STATE DEPARTMENT OF HEALTH

12467

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE W. Va		COUNTY Berkley	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Rural-Hagerstown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Martinsburg, - Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS R. # 1		(If rural, give location) 85x-3	
3. NAME OF DECEASED (Type or Print) Chester		(First) (Middle) (Last) Bowman		4. DATE OF DEATH Dec. 11 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar. 5, 1942	9. AGE last birthday 13 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Warren C. Bowman			14. MOTHER'S MAIDEN NAME Helen V. Hess		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war dates of service) No		16. SOCIAL SECURITY No. -		17. INFORMANT Walter Hess - Martinsburg, R # 1 W. Va.	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 816X Immediate cause (a) Fractured Skull Antecedent cause(s) Multiple fractures ribs, hemorrhage and shock Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) none					INTERVAL BETWEEN ONSET AND DEATH 5 min
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION --			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Highway		(CITY OR TOWN) (COUNTY) (STATE) Rural - Hagerstown, Wash. Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 11 '55 7:10PM		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Auto - Truck Collision	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE Robert Wells, M.D.		(Degree or title) DEPUTY		DATE SIGNED 12-13-55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 12-15-55		NAME OF CEMETERY OR CREMATORY Butler's Chapel	
LOCATION (City, town, or county) (State) Martinsburg, R # 1 W. Va.		24. FUNERAL DIRECTOR Scott F. Minnick & Son - Hagerstown, Md.			
DATE REC'D BY LOCAL REG Dec. 12, 1955		REGISTRAR'S SIGNATURE Chas. H. Howard			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

DEC 14 1955

RECEIVED

12388

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

12468

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE W. Va COUNTY Berkley	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Martinsburg - Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hagerstown, Maryland		STREET ADDRESS (If rural, give location) R # 1	
3. NAME OF DECEASED (Type or Print) Helen (First) Virginia (Middle) Bowman (Last)		4. DATE OF DEATH Dec. 11 (Month) 1955 (Year)	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 27, 1922 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Berkley County, W. Va.
13. FATHER'S NAME Canie Hess		14. MOTHER'S MAIDEN NAME Cora C. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Walter E. Hess, Martinsburg, W. Va. R # 1
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Open fracture of skull,			5 min.
Antecedent cause(s) (b) Closed fracture rt. tibia & fibula			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hemorrhage and shock			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION -	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) Highway		(CITY OR TOWN) Rural - Hagerstown 2 (COUNTY) Wash (STATE) Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 11 '55 7:10 PM		HOW DID INJURY OCCUR? Auto - Truck Collision	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <i>Robert M. Kelly, M.D.</i>		ADDRESS 115 N. Potomac St Hagerstown, Md 12-12-55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 12-15-55	
NAME OF CEMETERY OR CREMATORY Butler's Chapel		LOCATION (City, town, or county) (State) Martinsburg, R # 1 W. Va.	
DATE REC'D BY LOCAL REG. Dec. 12, 1955		24. FUNERAL DIRECTOR Scott F. Minnick & Son- Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

12389

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

12469

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE W. Va. COUNTY Berkley	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural- Hagerstown		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Martinsburg, W. Va.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS R # 1	
3. NAME OF DECEASED (Type or Print)		(First) John (Middle) Stewart (Last) Bowman		4. DATE OF DEATH Dec. 11 '55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH	9. AGE last birthday 15 yrs.	If under 1 year Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.	
13. FATHER'S NAME Warren C. Bowman		14. MOTHER'S MAIDEN NAME Helen V. Hess		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT AND ADDRESS Walter Hess- Martinsburg, W. Va.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Fractured skullINTERVAL BETWEEN
ONSET AND DEATH**1 min**

Antecedent cause(s)

Disease or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(c)

hemorrhage and shock

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.**--**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY Highway		(CITY OR TOWN) Rural- Hagerstown, Md. Wash. (COUNTY) Md. (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 11 '55 7:10PM		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Auto- Truck Collision	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

SIGNATURE J. Robert Wells, M.D.		DEPUTY MEDICAL EXAMINER		ADDRESS 115 N. Potomac St- Hagerstown, Md. 12-13-55	
MANNER OF DEATH Burial (Specify)		DATE THEREOF 12-15-55		NAME OF CEMETERY OR CREMATORY Butler's Chapel	
DATE REC'D BY LOCAL REG. Dec. 12, 1955		REGISTRAR'S SIGNATURE W. H. Bowers		24. FUNERAL DIRECTOR Scott F. Minnick & Son - Hagerstown, Md.	
				LOCATION (City, town, or county) (State) Martinsburg, W. Va. R#1	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED

INSTRUCTIONS

1 The law requires that the death certificate be executed within 2 hours after death.

2 The bottom copy may be retained by the hospital or attending physician.

3 The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12406

CERTIFICATE OF DEATH

12390

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>Life 16hr</u>		TOWN <u>Hagerstown</u>		03	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>132 N. Locust St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Theodore Columbus Bowman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 16 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>FEB 26, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Power</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred C. Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-2866</u>		17. INFORMANT & ADDRESS <u>Donald E. Eyer 410 Sherwood Dr Hagerstown Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>acute coronary-thrombosis</u>						<u>26hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio sclerotic coronary heart disease</u>						<u>5yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 16, 1955</u> , to <u>Dec. 16, 1955</u> , that I last saw the deceased alive on <u>Dec. 16, 1955</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Robert Wells</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 N. Potomac Street-Hagerstown, Md</u>			
DATE <u>Dec. 19, 1955</u>				DATE SIGNED <u>12-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Smithburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithburg, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Sharon Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc</u>		ADDRESS <u>Wm. A. Stark</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 11

Reg. Cert. No.

1. USUAL RESIDENCE (Inquirer's name)

Washington, D.C.

2. PLACE OF DEATH

Washington

3. PLACE OF BIRTH

Washington

4. DATE OF BIRTH

Washington (cont. to p. 1)

5. DATE OF DEATH

Theresa, Columbia

6. SEX

Married Feb 22, 1928

White

7. OCCUPATION (If deceased was a professional, business, or service person, give occupation)

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

BUREAU V. 1

DEC 22 1955

RECEIVED

12/22/55 2nd Deputy Comptroller

12/22/55 2nd Deputy Comptroller

INSTRUCTIONS

12407

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY <u>30 yrs.</u> in this place		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>305 S. Cleveland Ave</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Anna Mary Boyd</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 22 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan. 9, 1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>resturant</u>	11. BIRTHPLACE (State or foreign country): <u>Maugansville Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William C. Myers</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Brukaker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>214-09-6466</u>		17. INFORMANT & ADDRESS: <u>Harvey D. Martin Chambersburg Rt.5</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>						2 hrs.	
ANTECEDENT CAUSE (S): (B) <u>Diabetes Mellitus</u>						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetic Coma</u>						2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 21, 1955</u> , to <u>Dec. 22, 1955</u> , that I last saw the deceased alive on <u>Dec. 22nd, 1955</u> , and that death occurred at <u>5</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		DATE SIGNED <u>12/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Stouffer Mennonite</u>		LOCATION (City, town, or county) (State) <u>Near Smithsburg Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Scott F. Minnich & Son Hag. Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12392

12470

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY <u>160 E. Main St Hancock Md.</u>		CITY <u>160 E. Main St Hancock Md.</u>	
CITY <u>160 E. Main St Hancock Md.</u>		LENGTH OF STAY <u>(in this place)</u>		TOWN <u>160 E. Main St Hancock Md.</u>		STREET ADDRESS <u>160 E. Main St Hancock Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS <u>160 E. Main St Hancock Md.</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Alonzo</u>		(Middle) <u>Edward</u>		(Last) <u>Brakeall</u>		(Date) <u>12 29 19 55</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-6-05</u>	
9. AGE last birthday <u>50</u> yrs.		IF UNDER 1 YEAR <u>7</u> Months <u>23</u> Days		IF UNDER 24 HRS. <u>19</u> Hours <u>55</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md State Roads Dep.</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Asa M Brakeall</u>				14. MOTHER'S MAIDEN NAME <u>Susan Manning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-09-7105</u>		17. INFORMANT & ADDRESS <u>Mrs Minnie M Brakeall Hancock Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocarditis (Chy.)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Infarction</u>						<u>Mar. '54</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-20-55</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>12-20-55</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar</u> , 19 <u>55</u> , to <u>12-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Herbert R. Tobias</u>				ADDRESS (Street, city, town, state) <u>Berkeley Springs W. Va</u>		DATE SIGNED <u>12-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Toroway Cemetery</u>	
24. REC'D BY REGISTRAR <u>12/31/55</u>				REGISTRAR'S SIGNATURE <u>J. A. Keller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Grove Hancock Md</u>	
DATE				ADDRESS			

CERTIFICATE OF DEATH

Reg. Dist. No.

ST. MARY'S HOSPITAL (NORTH) OF BALTIMORE

MARYLAND

CITY OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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BUREAU V. S.

JAN 2 1966

RECEIVED

UNCLASSIFIED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12-10-55 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12393
 D.M.E. Wash. Co. h.d. CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH: 12408				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington MARYLAND				STATE Md. COUNTY Wawhington			
CITY (If outside corporate limits, write RURAL OR TOWN) 03 Hagerstown		LENGTH OF STAY (in this place) 1 day		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Hagerstown X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. County Hospital				STREET ADDRESS (If rural give location) Route 6			
3. NAME OF DECEASED: (First) (Middle) (Last) Raymond Earl Brewer				4. DATE (Month) (Day) (Year) OF DEATH: Dec 6 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Oct. 9, 1887	9. AGE last birthday: 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now) Clerk				10B. KIND OF BUSINESS OR INDUSTRY: Railroad		11. BIRTHPLACE (State or foreign country): Hagerstown Md.	
13. FATHER'S NAME: George Brewer				14. MOTHER'S MAIDEN NAME: Susan Bryerly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W. War 1				16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS: Mrs. Amy M. Brewer Route 6	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 332X Cerebral thrombosis						2 days	
ANTECEDENT CAUSE (S) DUE TO General arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST 904.9 DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture right femur						10 days	
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? 21	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 5, 1955, to Dec 6, 1955, that I last saw the deceased alive on Dec 6, 1955, and that death occurred at 10 P. M. from the causes and on the date stated above.							
SIGNATURE P. S. Stauffer				ADDRESS M. D. Hagerstown Md		DATE SIGNED Dec 7, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-9-55		NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		LOCATION (City, town, or county) (State) Beaver Creek Md.	
DATE REC'D BY LOCAL REGISTRAR Dec 9, 1955		REGISTRAR'S SIGNATURE B. A. Bowers		24. FUNERAL DIRECTOR Scott F. Minnich & Son Inc. M		ADDRESS	

BUREAU V. 2

DEC 12 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12471

CERTIFICATE OF DEATH

12394

304

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Hancock</u>		<u>Life</u>		TOWN <u>Hancock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Leon Wallard Brumback</u>				<u>12 24 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 30 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. Glass Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis G Brumback</u>				14. MOTHER'S MAIDEN NAME <u>Elouise Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Mary F Brumback Hancock Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>002X</u>				<u>Pulmonary Tuberculosis</u>		<u>months</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/16</u>, 19<u>55</u>, to <u>12/24</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/24</u>, 19<u>55</u>, and that death occurred at <u>9:54</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. M. Shaffer</u> M.D.				ADDRESS (Street, city, town, state) <u>Hancock Md</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>House of Jacob Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hancock Washington Md</u>	
24. REC'D BY REGISTRAR <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>J. H. Keller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Honorable & Grace Hancock Md</u>		ADDRESS	

CERTIFICATE OF DEATH

307

1. SHORT NUMBER HEALTH OFFICE

2. NAME OF DEATH

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

3. NAME OF DEATH
4. SEX
5. AGE

6. OCCUPATION
7. COLOR

8. BIRTH DATE
9. BIRTH PLACE

10. MARITAL STATUS
11. EDUCATION

12. RELIGION
13. SERVICE

14. PREVIOUS ILLNESS
15. PREVIOUS SURGERY

16. PREVIOUS TRAUMA
17. PREVIOUS DRUGS

18. PREVIOUS ALCOHOL
19. PREVIOUS TOBACCO

20. PREVIOUS OTHER
21. PREVIOUS OTHER

22. PREVIOUS OTHER
23. PREVIOUS OTHER

24. PREVIOUS OTHER
25. PREVIOUS OTHER

26. PREVIOUS OTHER
27. PREVIOUS OTHER

28. PREVIOUS OTHER
29. PREVIOUS OTHER

30. PREVIOUS OTHER
31. PREVIOUS OTHER

BUREAU V. S.

DEC 29 1955

RECEIVED

12/29/55
J. H. Miller

1
RECEIVED
BALTIMORE
STATE DEPARTMENT OF HEALTH
BALTIMORE
12/29/55
J. H. Miller

12409

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md	COUNTY Washington
CITY (If outside corporate limits, write RURAL or and give nearest town) Hagerstown	LENGTH OF STAY (in this place) 62 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 E. Franklin St		STREET ADDRESS (If rural give location) 310 E. Franklin St.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Mary Ann Bush		Dec. 20 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Oct. 31, 1893
9. AGE last birthday 62 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): Hagerstown Md.
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) weaver		10B. KIND OF BUSINESS OR INDUSTRY: Knitting Mill	
11. BIRTHPLACE (State or foreign country): Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John C. Baker		14. MOTHER'S MAIDEN NAME: Beda B. Harbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	
17. INFORMANT & ADDRESS: William Cushwa Hag. Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Thrombosis			1 hour
ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic heart disease			unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive cardio vascular disease			13 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Residual hemiplegia			5 yrs
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from April 1, 1942 , to Dec. 20, 1955 that I last saw the deceased alive on Dec. 20, 1955 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
SIGNATURE W. T. Layman, M.D.		ADDRESS Hagerstown, Md.	
DATE SIGNED Dec. 20, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-22-55	
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Dec 22 1955		REGISTRAR'S SIGNATURE Charles H. Bowers	
24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12396

Dr Hornbaker

12410

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
03 TOWN <u>Hagerstown</u>		3 Days		TOWN <u>Hagerstown</u>		03	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
81 <u>Wash. County Hospital</u>				402 Summit Ave			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>GEORGE RICHARD BUSSARD</u>				<u>Dec 2 1955</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Jan 4 1883	72 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Insurance Salesman</u>					<u>Baltimore Md</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Luther M. Bussard</u>				<u>Annie Heyser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
4 No				<u>Mrs Mary M. Bussard</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u>						12 hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						4 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
2							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 5/3, 1938, to 12-2, 1955, that I last saw the deceased alive on 12/2/55, 1955, and that death occurred at 4:50 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John H. Hornbaker</u>		<u>154 W. Washington St</u>		<u>Hagerstown, Md</u>		<u>12-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEROF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial	12/4/55	Rose Hill Cemetery		Hagerstown Wash. Co. Md			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
DATE	<u>Dec. 5, 1955</u>	<u>Charles K. Rowers</u>		<u>Andrew K. Coffman Hagerstown Md.</u>			

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

MARY ANN

2. PLACE OF BIRTH

CHINA

3. DATE OF BIRTH

1900

4. SEX

FEMALE

5. OCCUPATION

SEWING

6. MARITAL STATUS

SINGLE

7. CAUSE OF DEATH

HEART DISEASE

8. PLACE OF DEATH

HOME

9. DATE OF DEATH

1955

10. SIGNATURE OF PHYSICIAN

J. H. SMITH

11. SIGNATURE OF REGISTRAR

W. H. JONES

12. SIGNATURE OF WITNESSES

A. B. C. D. E.

13. SIGNATURE OF DECEASED

MARY ANN

14. SIGNATURE OF BURIAL OFFICIAL

F. G. H. I. J.

15. SIGNATURE OF INTERVIEWER

K. L. M. N. O.

16. SIGNATURE OF CORONER

P. Q. R. S. T.

EXHIBITION

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

BUREAU V. E.

DEC 7 1955

RECEIVED

12472

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells 12397
Reg. Dist.

No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Williamsport</u>		LENGTH OF STAY (In this place) --		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Williamsport R # 2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route # 11</u>				STREET ADDRESS <u>Reynolds Ave</u> (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First) <u>MABELLE</u>		(Middle) <u>VIRGINIA</u>		(Last) <u>CARLISLE</u>	
4. DATE OF DEATH		(Month) <u>Dec</u>		(Day) <u>26</u>		(Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>May 16 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Front Royal Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George F. Kirby</u>				14. MOTHER'S MAIDEN NAME: <u>Flora May Silman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>314-16-0731</u>		17. INFORMANT & ADDRESS: <u>Mrs Goldie Leatherman</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause		(a) <u>Fractured skull - hemorrhage & shock</u>		DUE TO		<u>5 min.</u>	
Antecedent cause(s)		(b) <u>Open fractured lt. tibia & fibula</u>		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>none</u>		<u>-</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) (County) <u>21</u> (State) <u>21</u>			
<u>Rural - Williamsport, Md. Wash. Md</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 26 '55 7:30 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Pedestrian - struck by Automobile</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. Robert Wells</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Blair H. Howers</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1956

BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
12473 **CERTIFICATE OF DEATH** Dr LeVan

12398

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Boonsboro</u>		<u>2 Weeks</u>		TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reeder Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Calvert Apartments</u>			
3. NAME OF DECEASED (Type or Print) <u>EMMA</u> (First) <u>VIRGINIA</u> (Middle) <u>CARR</u> (Last)				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 14 1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ann Lantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Dessie Harp</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<u>450.0</u>		<u>Generalized arteriosclerosis with aneurysm</u>				<u>6 yrs</u>	
IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 13, 1955</u> to <u>Dec 28, 1955</u> that I last saw the deceased alive on <u>Dec 23, 1955</u> and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr LeVan</u>		M. D.		ADDRESS (Street, city, town, state) <u>Boonsboro</u>		DATE SIGNED <u>12/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithsburg Wash. Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. Bail</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown</u>	
DATE <u>Dec. 29. 55</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

2. CAUSE OF DEATH
 a. Immediate Cause
 b. Intermediate Cause
 c. Remote Cause

3. SEX
 a. Male
 b. Female

4. AGE
 a. At Birth
 b. At Death

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. PREVIOUS ILLNESS

12. PREVIOUS SURGERY

13. PREVIOUS TRAUMA

14. PREVIOUS DRUGS

15. PREVIOUS ALCOHOL

16. PREVIOUS TOBACCO

17. PREVIOUS OTHER

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

30. PREVIOUS OTHER

31. PREVIOUS OTHER

32. PREVIOUS OTHER

33. PREVIOUS OTHER

34. PREVIOUS OTHER

35. PREVIOUS OTHER

36. PREVIOUS OTHER

37. PREVIOUS OTHER

38. PREVIOUS OTHER

39. PREVIOUS OTHER

40. PREVIOUS OTHER

BUREAU V. S.

RECEIVED

ENCLOSURE

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEC. 30 '55
J.R. [unclear] M.D.
Consul General. D.M.F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12399
Reg. Dist. No. 302

CERTIFICATE OF DEATH

1. PLACE OF DEATH: 12411		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Maryland	COUNTY Washington
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Hagerstown	LENGTH OF STAY (in this place) 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		STREET ADDRESS (If rural give location) 732 Washington Ave,	
3. NAME OF DECEASED: (First) JOHN (Middle) HAMPDEN (Last) COSENS		4. DATE (Month) (Day) (Year) OF DEATH: December 23 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: November 19, 1822
		9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months 1 Days 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) Retired Machinist		10B. KIND OF BUSINESS OR INDUSTRY: Western Maryland R. R.	11. BIRTHPLACE (State or foreign country): Staunton, Virginia
13. FATHER'S NAME: Henry J. Cosens		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME: Georgina Goutsch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. 705-10-5538	
17. INFORMANT & ADDRESS: Robert I. Cosens Greencastle Rt. # 2 Pa.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			ONE WEEK
(A) TRAUMATIC PNEUMONIA			
IMMEDIATE CAUSE 904.0			
(B) ANTECEDENT CAUSE (S) DUE TO FRACTURED RIBS			3 WEEKS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			UNKNOWN
ARTERIOSCLEROSIS			UNKNOWN
HYPERTENSIVE CARDIOVASCULE RENAL DISEASE			
19A. DATE OF OPERATION: NONE	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) HOME	21C. WHERE DID (City or town) INJURY OCCUR? HAGERSTOWN WASHINGTON MARYLAND	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY DECEMBER 4, 1955	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	21F. HOW DID INJURY OCCUR? FELL	
22. I hereby certify that I attended the deceased from DEC 6, 1955, to DEC 23, 1955, that I last saw the deceased alive on DEC. 22, 1955, and that death occurred at 5-25 A.M. from the causes and on the date stated above.			
SIGNATURE [Signature]		DATE SIGNED DEC. 24, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/26/1955	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
		LOCATION (City, town, or county) (State) Hagerstown, Maryland	
DATE REC'D BY LOCAL REGISTRAR Dec. 27, 1955		REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR C. M. Suter & Sons Hagerstown, Maryland

RECEIVED

JAN 2 1956

BUREAU V. S.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12412 **CERTIFICATE OF DEATH**

12400

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		MARYLAND		STATE MARYLAND		COUNTY WASHINGTON	
CITY OR TOWN HAGERSTOWN		LENGTH OF STAY (in this place) 7 YRS.		CITY OR TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 NORTH AVE.				STREET ADDRESS 104 NORTH AVE.		(If rural give location)	
3. NAME OF DECEASED (First) SUE (Middle) ELSIE (Last) DAUBERT				4. DATE OF DEATH (Month) DEC. (Day) 2 (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, WIDOWED	8. DATE OF BIRTH 10/21/1880		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB KERSTETTER				14. MOTHER'S MAIDEN NAME ? KERSTETTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MISS ETHEL M. DAUBERT HAGERSTOWN MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						17 yr	
420.0 IMMEDIATE CAUSE (A) Arterio Sclerotic Heart disease with							
ANTECEDENT CAUSE(S) DUE TO (B) myocardial failure							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1948 to 1955, that I last saw the deceased alive on 3 Dec 1957 and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE J F Lusby		ADDRESS (Street, city, town, state) M.D. 2301 Potomac		DATE SIGNED 5 Dec 57			
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 12/7/55		NAME OF CEMETERY OR CREMATORY HARMONY CEM.		LOCATION (City, town, or county) (State) MILTON PENNA.	
24. REC'D BY REGISTRAR Dec. 7, 1955		REGISTRAR'S SIGNATURE Charles Bowers		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		ADDRESS Hagerstown, Md.	

CERTIFICATE OF DEATH

12450

Reg. Dist. 116

IN A LAST RESPIRATION (NAME OF DECEASED)

PLACE OF DEATH

DAVID J. HARRINGTON

FASHINGTON

DATE OF DEATH

12-11-55

TIME OF DEATH

10:00 P.M.

104 NORTH AVE.

104 NORTH AVE.

DAVID J. HARRINGTON

WEST

8:00

104 NORTH AVE.

STONED

REMARKS WITH

PLAIN X-RAYS

HOME

100-2111

12-11-55

JACOB HARRINGTON

12-11-55

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BUREAU A. 8

DEC 9 1955

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MITCHELL

HARMONY GUN

LEAVES

GUTHRIE

12-11-55

12413

CERTIFICATE OF DEATH

Reg. Dist. No.

12401

382

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WASHINGTON</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>WASHINGTON</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
<u>83</u> TOWN <u>HAGERSTOWN</u>	<u>24 HOURS</u>	<u>CAVETOWN PIKE. RURAL X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS	(If rural give location)	
<u>81</u> <u>WASH. CO. HOSPITAL</u>	<u>HAGERSTOWN MD. R. 1</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)	DATE OF DEATH:	<u>DECEMBER 9, 1955</u>	
<u>HENRY C</u>	<u>DIBERT</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>MAY 15, 1869</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
<u>RETIRED TRUCK FARMER. OWN FARM</u>	<u>CHENSVILLE WASH. CO. MD.</u>	<u>86-6-24</u>	<u>86-6-24</u>
11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>U.S.A.</u>	<u>U.S.A.</u>		
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<u>JACOB DIBERT</u>	<u>ELIZABETH HOOVER</u>		
15. WAR DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
<u>3 NO</u>	<u>219-12-0191</u>	<u>MRS. AMY B. RICE HAGERSTOWN MD. R. 1</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>Several short hrs.</u>	
ANTECEDENT CAUSE (S) (B) <u>General arteriosclerosis and cerebral sclerosis</u>		<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Chronic cholecystitis with cholelithiasis</u>		<u>Indefinite</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 5, 1955</u> to <u>Dec. 9, 1955</u> , that I last saw the deceased alive on <u>Dec. 8, 1955</u> and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Dec. 12, 1955</u>	
M.D. <u>Hagerstown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>DEC. 12, 1955</u>	<u>REST HAVEN CEMETERY</u>	<u>HAGERSTOWN MD. R. 1</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>Dec. 12, 1955</u>	<u>[Signature]</u>	<u>Wm. F. East & Sons, Boonsboro, Md.</u>	

Dr. B. B. KNEISLY
148 W. WASHINGTON
HAGERSTOWN, MD.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12402

Dr. Cohen

12414 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>4 yrs</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>351 Devonshire Rd.</u>				<u>351 Devonshire Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>Webster</u> (Last) <u>Duvall</u>				(Month) <u>Dec.</u> (Day) <u>34</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 29, 1881</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Roof Builder</u>		<u>Self Employed</u>		<u>Ridgeville, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Duvall</u>				<u>Catherine Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>184-38-3855</u>		<u>Mary Elizabeth Duvall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerosis, generalized</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Diabetes Mellitus</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						3 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>Nov. 30, 1955</u>		<u>Arteriosclerotic gangrene</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 3, 1954</u> to <u>Dec. 24, 1955</u> , that I last saw the deceased alive on <u>Dec. 23, 1955</u> , and that death occurred at <u>11:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Archie Robert Cohen</u> M.D.				ADDRESS (Street, city, town, state) <u>Clear Spring, Maryland</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-28-1955</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown Wash. Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 29, 1955</u>		<u>Wesley H. Powers</u>		<u>Andrew K. Coffman</u>		<u>Hagerstown, Md.</u>	

1914 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. COLOR

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. PREVIOUS ILLNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF STATE

24. SIGNATURE OF NATION

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91. SIGNATURE OF PRESSURE

92. SIGNATURE OF HUMIDITY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812403

12474 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X Maugansville		13 yrs.		Maugansville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: Dec. 19 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: Aug. 6, 1892	
9. AGE last birthday: 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife		11. BIRTHPLACE (State or foreign country): Ganoetown W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: James Mason				14. MOTHER'S MAIDEN NAME: Esther Manor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. -			
17. INFORMANT & ADDRESS: E. Wade Ewan Maugansville Md.							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Embolus							
ANTECEDENT CAUSE (S) DUE TO (B) Phlebitis Femoral Vein							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0 19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-25 , 1955, to 12-19 , 1955, that I last saw the deceased alive on 12-19 , 1955, and that death occurred at Home , from the causes and on the date stated above.							
SIGNATURE A. Sw. Smith		ADDRESS Hagerstown Md.		DATE SIGNED 12-20-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-21-55		NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		LOCATION (City, town, or county) (State) Winchester Va.	
DATE REC'D BY LOCAL REGISTRAR Dec 20, 1955		REGISTRAR'S SIGNATURE W. H. Rowers		24. FUNERAL DIRECTOR Scott F. Minnich & Son Hag. Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 22 1955

RECEIVED

12475 CERTIFICATE OF DEATH

Reg. Dist. No. 305...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BOONSBORO</u>				CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BOONSBORO</u>			
TOWN <u>BOONSBORO</u>				TOWN <u>BOONSBORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. MAIN ST.</u>				STREET ADDRESS (If rural give location) <u>N. MAIN ST.</u>			
3. NAME OF DECEASED: (Type or Print) <u>HOWARD OSCAR FLOOK</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>DECEMBER - 20 - 1955</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>JULY-22-1878</u>	
9. AGE last birthday <u>77-4-28</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER - JANITOR SERVICE</u>		11. BIRTHPLACE (State or foreign country): <u>FREDERICK CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOSHUA HOWARD FLOOK</u>				14. MOTHER'S MAIDEN NAME: <u>LYDIA ANN MALINDA FLOOK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>3 NO.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>328-05-3645</u>		17. INFORMANT & ADDRESS: <u>MRS. EDNA REMSBURG BOONSBORO MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Thrombosis</u>						<u>sudden</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 20</u> , 19 <u>55</u> , to <u>Dec 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>55</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Boonsboro</u>		DATE SIGNED <u>12/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 23. 1955</u>		NAME OF CEMETERY OR CREMATORY <u>MAUSOLEUM</u>		LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 22. 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>WM. F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD.</u>	

DR. L E VAN

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12476

CERTIFICATE OF DEATH

Reg. Dist. No.

124066

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Smithsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Smithsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #2</u>		STREET ADDRESS (If rural give location) <u>RFD #2</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Archie Elmer Frey</u>		<u>Dec. 2, 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>Sept. 14, 1873</u>
9. AGE last birthday		10. AGE last birthday	
<u>82 yrs.</u>		<u>82 yrs.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>farmer</u>		<u>own farm</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Wolfsville, Md.</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Johnathan Frey</u>		<u>Susan Mary Swope</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>no</u>	
17. INFORMANT & ADDRESS:			
<u>Clarence Frey, Smithsburg, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE		(A) <u>Cerebral Vascular Accident</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Arteriosclerosis - Generalized</u>	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/1</u> , 19 <u>55</u> , to <u>12/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Charles E. Hess</u>		<u>12/3/55</u>	
M. D.		ADDRESS	
<u>Smithsburg, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>burial</u>		<u>12-5-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Welty's Cemetery</u>		<u>Smithsburg, RFD, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Dec 3-55</u>		<u>Geo. H. Ferguson</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Scott F. Minnich & Son, Smithsburg</u>			

RECEIVED

DEC 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812406
12415

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>03</u> TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>13</u> years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	<u>03</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>07</u> <u>425 West Franklin Street</u>	STREET ADDRESS (If Rural give location) <u>425 West Washington Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ADDIE</u> <u>FLORENCE</u> <u>FRYER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 5</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>November 20, 1871</u>
9. AGE last birthday <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Waynesboro, Penna.</u>
13. FATHER'S NAME: <u>Jacob D. Summers</u>		14. MOTHER'S MAIDEN NAME: <u>Mary A. Heefner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT & ADDRESS: <u>Mrs. Mildred G. Moss Hagerstown, Maryland</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Aretrio sclerotic myocardial heart disease</u>			
ANTECEDENT CAUSE (S) DUE TO <u>with myocardial failure grade Iv</u>			<u>3yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)			
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u> <u>none</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	21C. WHERE DID (City or town) INJURY OCCUR? <u>-</u>	(County) <u>-</u> (State) <u>-</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Dec. 5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. R. H. Wells M.D.</u>		ADDRESS <u>M. D. 115 N. Potomac St.- Hagerstown, Md</u>	
DATE SIGNED <u>Dec 7, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/8/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>Dec 7, 1955</u>	REGISTRAR'S SIGNATURE <u>Phyllis H. Bower</u>	24. FUNERAL DIRECTOR <u>C. M. Suter & Sons</u>	ADDRESS <u>Hagerstown, Maryland</u>

RECEIVED

COLLECTOR GENERAL

BUREAU V. S.

DEC 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

12407

12477

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 304

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>W. VA.</u> <u>Barbara</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Hancock 1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Buchannon</u> <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Accident on Route 40.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Evelyn</u>	(Middle)	(Last) <u>Goodwin</u>
4. DATE OF DEATH	(Month) <u>Dec.</u>	(Day) <u>24</u>	(Year) <u>1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 2/1921</u>
9. AGE last birthday <u>34</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Barbara County W. Va.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George A Phelps</u>		14. MOTHER'S MAIDEN NAME <u>Celia S Fauley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Dale Goodwin Bushannon W. Va.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Fractured cervical vertebrae</u>			<u>10 min</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Work</u> (CITY OR TOWN) <u>Hancock</u> (COUNTY) <u>Wash.</u> (STATE) <u>md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-24-55 11:15 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Passenger in auto collision</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. Robert Meeks M.D.</u>		DEPUTY MEDICAL EXAM. ADDRESS <u>Hagerstown, Md.</u> DATE SIGNED <u>Dec. 25 '58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12.28.55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Morris Cemetery</u>		LOCATION (City, town, or county) (State) <u>Clarksburg Barbara W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>12/25/58</u>		24. FUNERAL DIRECTOR ADDRESS <u>Howard F. Stone Hancock Md</u>	

BUREAU V. S.

DEC 30 1955

RECEIVED

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown, Md.</u> TOWN <u>Hagerstown, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>31 W Bethel Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> TOWN <u>Hagerstown Maryland</u> STREET ADDRESS (If rural give location) <u>31 W Bethel Street,</u>	
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>Harry</u> (no) <u>Gray</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>10</u> <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 15 1878</u>
9. AGE last birthday <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardener</u>	
11. BIRTHPLACE (State or foreign country) <u>Beaver Creek, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James Gray</u>		14. MOTHER'S MAIDEN NAME <u>Lula James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8789</u>	
17. INFORMANT & ADDRESS <u>Mrs. Minnie William. 31 W. Bethel</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>acute cerebral hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>vascular hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hemiplegia</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>5 yrs</u> <u>4 yrs</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>		20d. HOW DID INJURY OCCUR?	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work el work	
22. I hereby certify that I attended the deceased from <u>12-10-55</u> to <u>12-10-55</u>, that I last saw the deceased alive on <u>12-10-55</u>, and that death occurred at <u>5:15</u> M, from the causes and on the date stated above. SIGNATURE <u>Stokes Thells M.D.</u> M.D. ADDRESS (Street, city, town, state) <u>Hagerstown, Maryland.</u> DATE SIGNED <u>12-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. DATE THEREOF <u>12-14-1955</u>	
25. NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>		26. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland.</u>	
27. REC'D BY REGISTRAR <u>Dec. 14, 1955</u>		28. REGISTRAR'S SIGNATURE <u>John R. Watson</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson</u>		30. ADDRESS <u>Hagerstown, Md</u>	

CERTIFICATE OF DEATH

RECEIVED

THIS CERTIFICATE OF DEATH IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL.

RECEIVED
DEC 16 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

12409

12478

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 305

1. PLACE OF DEATH- COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) RURAL BOONSBORO HOSPITAL OR INSTITUTION OR STREET ADDRESS RT#1 BOONSBORO		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) RURAL BOONSBORO STREET ADDRESS RT#1 BOONSBORO	
3. NAME OF DECEASED (First) HARRY (Middle) CLYDE (Last) GROVE		4. DATE OF DEATH (Month) DEC. (Day) 14 (Year) 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED	8. DATE OF BIRTH 11/27/1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10b. KIND OF BUSINESS OR OCCUPATION OWN PRACTICE	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME HARRY C. GROVE		14. MOTHER'S MAIDEN NAME SUSAN DUCKETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) YES (If yes, give war or dates of service) W.W. #2		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS MRS. BEATRICE GROVE		18. ADDRESS BOONSBORO MD. RT#1	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) acute coronary occlusion		20 min
Antecedent cause(s) (b) none		
11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)		
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) none	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY none	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? -

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

S. P. Kelly

DEPUTY MEDICAL EXAM.

ADDRESS

DATE SIGNED

WASH. CO., MD.

115 N. Potomac St. -agerstown, Md. 12-16-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	12/17/55	St. Marks Epis. Ch. Cem.	Washington County, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec 16 1955	John H. Bass	W. J. Norment	agerstown, Md.

BUREAU V. S.

DEC 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12417 CERTIFICATE OF DEATH

12410

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN LENGTH OF STAY (in this place) 9 MO.		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL		STREET ADDRESS (If rural give location) 50 RANDOLPH AVE.	
3. NAME OF DECEASED (Type or Print) MYRLE (Myrle) HAZEL GRUGEL (First) (Middle) (Last)		4. DATE OF DEATH DEC. 15 19 55 (Month) (Day) (Year)	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 2/26/1888
9. AGE last birthday 67 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR DRY CLEANING CO.		10b. KIND OF BUSINESS OR INDUSTRY NEBRASKA	
11. BIRTHPLACE (State or foreign country) NEBRASKA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUTHER GREENAWALT		14. MOTHER'S MAIDEN NAME EMILY COLTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 294-30-4837	
17. INFORMANT & ADDRESS MRS. HELEN BARNHART HAGERSTOWN MD.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
2040 IMMEDIATE CAUSE (A) Pulmonary Embolus			1-2 minutes
ANTECEDENT CAUSE(S) DUE TO (B) Pathologic Fracture Body of D11 + L-3			8 weeks
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Lymphatic Leukemia			11 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-6- , 19 55 , to 12-15 , 19 55 , that I last saw the deceased alive on 12-15 , 19 55 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.			
SIGNATURE Dalton M. Welch M.D.		ADDRESS (Street, city, town, state) Hagerstown, Washington Co. 12/16/55	
23. BURIAL, CREMATION, REINTERMENT (SPECIFY) BURIAL		DATE THEREOF 12/29/55	
NAME OF CEMETERY OR CREMATORY LAKEWOOD CEM.		LOCATION (City, town, or county) (State) AKRON OHIO	
24. REC'D BY REGISTRAR Dec. 16, 1955 REGISTRAR'S SIGNATURE Chas H Bowers		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne ADDRESS Hagerstown, Md.	

MAY 1992

• A U T H

DEC 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **12411**
12418 CERTIFICATE OF DEATH

Reg. Dist. No. **302**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Wash	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hagerstown		few min		TOWN Sharpsburg, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS A & P Store				STREET ADDRESS (If rural give location) 205 E. Antietam St-			
N. Potomac St- Hagerstown, Md.							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Charles Albert Guessford				Dec. 15 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Apr. 4, 1908	
				9. AGE last birthday: 47 yrs.		IF UNDER 1 YEAR: 8 Months 10 Days 10 Hours 5 Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY: Ice Cream Co.		11. BIRTHPLACE (State or foreign country): Hagerstown	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Robert L. Guessford				14. MOTHER'S MAIDEN NAME: Sarah Jane Barnhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No.: 214-09-6339		17. INFORMANT & ADDRESS: Mrs. Ruth Guessford - 205 E. Antietam St Sharpsburg, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause (a) Coronary Occlusion						5 min	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized atherosclerosis						5-6	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? No							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from 12-15-55 , 19 55 , to 12-15-55 , 19 55 , that I last saw the deceased alive on 12-15-55 , 19 55 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
SIGNATURE R. W. Smith				ADDRESS Hagerstown, Md.		DATE SIGNED 12-17-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 18 '55		Mt. View Cemetery		Sharpsburg, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 17, 1955		R. W. Smith		Albert L. Leaf- Williamsport, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 20 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

12419

1. PLACE OF DEATH: WASHINGTON COUNTY HOSPITAL KING ST. HAGERSTOWN, MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY WASHINGTON		MARYLAND		STATE W.V.		COUNTY MORGAN	
CITY (If outside corporate limits, write OR and give nearest town) HAGERSTOWN		RURAL LENGTH OF STAY (in this place) 12 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) BERKELEY SPRINGS 85X-8			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL				STREET ADDRESS (If rural give location) R.F.D. # 3			
3. NAME OF DECEASED: (First) (Middle) (Last) ELMER HOWARD HADDOX				4. DATE OF DEATH: (Month) (Day) (Year) Dec. 16, 1955			
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: OCT. 13, 1881	
9. AGE last birthday: 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: TELEGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD		11. BIRTHPLACE (State or foreign country): JONES SPRINGS, W.V.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: ALPHEUS LEWIS HADDOX				14. MOTHER'S MAIDEN NAME: HARRIET BARTELBAUGH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: MRS. EVELYN HASENBUNLER BERKELEY SPRINGS, W.V.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.6 Immediate cause (a) UREMIA DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) METASTATIC CARCINOMA INVOLVING EIGHTH DORSAL DUE TO (c) VERTEBRA; SIXTH RIB; PARALYSIS BELOW EIGHT DORSAL						Interval Between Onset And Death 7 DAYS 12 DAYS CERTAIN; TIME OF OR UNKNOWN	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE							
19a. DATE OF OPERATION: NONE						19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from DECEMBER 14, 1955 to DEC. 16, 1955, that I last saw the deceased alive on DEC. 16, 1955, and that death occurred at 1:40 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) W. T. LAYMAN, M.D. ADDRESS DEC. 16, 1955 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
REMOVAL		12-16-55		GREENWAY		BERKELEY SPRINGS W.V.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
DEC. 16, 1955		W. T. Layman, M.D.		J. H. Smith		BERKELEY SPRINGS, W.V.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12479 CERTIFICATE OF DEATH

12413
Reg. Dist. No. 306

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rural, Smithsburg</u>		<u>50 Yrs.</u>		TOWN <u>Rural, Smithsburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smithsburg #2</u>				STREET ADDRESS (If rural give location) <u>Smithsburg #2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Carrie</u> (Middle) <u>Belle</u> (Last) <u>Hahn</u>				(Month) <u>Dec.</u> (Day) <u>13,</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 14, 1886</u>	<u>69 yrs.</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>House Wife</u>		<u>Rouzersville, Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Eli Ott</u>				<u>Emma Jane Shettle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>0</u>		<u>Mrs. Marie Thompson, Waynesboro, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>1 da</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Hypertension & atherosclerosis</u>		<u>10 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-13-55</u> , 19 <u>55</u> , to <u>12-13-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-13-55</u> , 19 <u>55</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. J. Tindeman</u> M.D.				ADDRESS (Street, city, town, state) <u>Waynesboro Pa</u>		DATE SIGNED <u>12-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/17/55</u>		<u>Bethel</u>		<u>Lantz #1, Frederick Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE Dec 14-55</u>		<u>E. H. Ferguson</u>		<u>Walter J. Love</u>		<u>Waynesboro Pa</u>	

CERTIFICATE OF DEATH

1919

Reg. Dist. No.

1. FULL RESIDENCE, HOME OR PLACE OF DEATH

2. PLACE OF DEATH

3. DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF COURT

24. SIGNATURE OF STATE

25. SIGNATURE OF COUNTY

26. SIGNATURE OF CITY

27. SIGNATURE OF TOWNSHIP

28. SIGNATURE OF PARISH

29. SIGNATURE OF VILLAGE

30. SIGNATURE OF HAMLET

31. SIGNATURE OF CENSUS TRACT

32. SIGNATURE OF BLOCK

33. SIGNATURE OF HOUSEHOLD

34. SIGNATURE OF ROOM

35. SIGNATURE OF BED

36. SIGNATURE OF CHAIR

37. SIGNATURE OF TABLE

38. SIGNATURE OF CUPBOARD

39. SIGNATURE OF WARDROBE

40. SIGNATURE OF CLOSET

41. SIGNATURE OF BATH

42. SIGNATURE OF KITCHEN

43. SIGNATURE OF LIVING ROOM

44. SIGNATURE OF BED ROOM

45. SIGNATURE OF PORCH

46. SIGNATURE OF PATIO

47. SIGNATURE OF GARDEN

48. SIGNATURE OF YARD

49. SIGNATURE OF DRIVE

50. SIGNATURE OF WALK

51. SIGNATURE OF FENCE

52. SIGNATURE OF GATE

53. SIGNATURE OF DOOR

54. SIGNATURE OF WINDOW

55. SIGNATURE OF ROOF

56. SIGNATURE OF FLOOR

57. SIGNATURE OF CEILING

58. SIGNATURE OF WALL

59. SIGNATURE OF BASE

60. SIGNATURE OF MOLDING

61. SIGNATURE OF TRIM

62. SIGNATURE OF FINISH

63. SIGNATURE OF PAINT

64. SIGNATURE OF STAIN

65. SIGNATURE OF GLASS

66. SIGNATURE OF CERAMIC

67. SIGNATURE OF METAL

68. SIGNATURE OF WOOD

69. SIGNATURE OF PLASTER

70. SIGNATURE OF CONCRETE

71. SIGNATURE OF BRICK

72. SIGNATURE OF BLOCK

73. SIGNATURE OF TILE

74. SIGNATURE OF SLATE

75. SIGNATURE OF SHINGLE

76. SIGNATURE OF ASPHALT

77. SIGNATURE OF RUBBER

78. SIGNATURE OF LEAD

79. SIGNATURE OF ZINC

80. SIGNATURE OF COPPER

81. SIGNATURE OF ALUMINUM

82. SIGNATURE OF STEEL

83. SIGNATURE OF IRON

84. SIGNATURE OF SODIUM

85. SIGNATURE OF POTASSIUM

86. SIGNATURE OF CALCIUM

87. SIGNATURE OF MAGNESIUM

88. SIGNATURE OF PHOSPHORUS

89. SIGNATURE OF SULFUR

90. SIGNATURE OF CHLORINE

91. SIGNATURE OF FLUORINE

92. SIGNATURE OF BROMINE

93. SIGNATURE OF IODINE

94. SIGNATURE OF BARIUM

95. SIGNATURE OF STRONTIUM

96. SIGNATURE OF RADIUM

97. SIGNATURE OF POLONIUM

98. SIGNATURE OF ACTINIUM

99. SIGNATURE OF THORIUM

100. SIGNATURE OF URANIUM

101. SIGNATURE OF PLUTONIUM

102. SIGNATURE OF AMERIUM

103. SIGNATURE OF CURIUM

104. SIGNATURE OF FERMIUM

105. SIGNATURE OF MENDENHALLIUM

106. SIGNATURE OF NOBELIUM

107. SIGNATURE OF RUTHERFORDIUM

108. SIGNATURE OF DAHLBERGIIUM

109. SIGNATURE OF SIEMENSIIUM

110. SIGNATURE OF COPELANDIUM

111. SIGNATURE OF LAWRENCIUM

112. SIGNATURE OF BERTHELIUM

113. SIGNATURE OF UNQUANTIFIED

114. SIGNATURE OF UNKNOWN

115. SIGNATURE OF UNIDENTIFIED

116. SIGNATURE OF UNCLASSIFIED

117. SIGNATURE OF UNRECORDED

118. SIGNATURE OF UNFILED

119. SIGNATURE OF UNINDEXED

120. SIGNATURE OF UNSEARCHED

121. SIGNATURE OF UNREVIEWED

122. SIGNATURE OF UNAPPROVED

123. SIGNATURE OF UNACCEPTED

124. SIGNATURE OF UNRECORDED

125. SIGNATURE OF UNFILED

NOTIFICATION

BUREAU V. S.

DEC 16 1955

RECEIVED

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Hirshman

12414

12420

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1114 Oak Hill Ave</u>				STREET ADDRESS (If rural give location) <u>1114 Oak Hill Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>ROSAMOND HAINES HASSETT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 31 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Sept 28 1872</u>	
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Green Spring Furnace</u>	
13. FATHER'S NAME <u>Merritt Haines</u>				14. MOTHER'S MAIDEN NAME <u>Leola Feidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mrs Elizabeth Ankeney</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerosis & Hypertensive Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Oct 1955</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19 1955</u>, to <u>Dec 31 1955</u>, that I last saw the deceased alive on <u>Dec 30 1955</u>, and that death occurred at <u>5:49 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. M. Leman</u>				ADDRESS (Street, city, town, state) <u>Hagerstown Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill cemetery near Clear Spring Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 3, 1956</u>		REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			

RECEIVED

1
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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12596

12480

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAGERSTOWN</u> TOWN <u>HAGERSTOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GATEWAY NURSING HOME</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> TOWN <u>HAGERSTOWN</u> STREET ADDRESS (If rural give location) <u>26 RANDOLPH AVE.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ALEXANDER</u> <u>HENSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC.</u> <u>24</u> <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>7/3/1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>	9. AGE last birthday <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS. MAUDE HENSON</u> <u>HAGERSTOWN MD.</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Carcinoma of prostate.</u> (C) <u>3 yrs.</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>3 yrs.</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>None</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>July 27, 1954</u> , to <u>Dec 24, 1955</u> , that I last saw the deceased alive on <u>Dec. 24, 1955</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>H. A. Bell</u> M.D. <u>Hagerstown, Maryland.</u> DATE SIGNED <u>12-27-55</u> ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/28/55</u>	
NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEM.</u>		LOCATION (City, town, or county) (State) <u>SHEPERDSTOWN W. VA.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec 31-55</u>		REGISTRAR'S SIGNATURE <u>Larry W. Forkler</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Horment, Hagerstown, Md.</u>		ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED MARYLAND WASHINGTON		PLACE OF DEATH MARYLAND WASHINGTON	
SEX FEMALE		AGE 74 YEARS	
DATE OF DEATH DEC. 19, 1933		PLACE OF BIRTH MARYLAND WASHINGTON	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH OLD AGE	
SIGNATURE OF DECEASED MARYLAND WASHINGTON		SIGNATURE OF WITNESSES MARYLAND WASHINGTON	
SIGNATURE OF PHYSICIAN MARYLAND WASHINGTON		SIGNATURE OF CORONER MARYLAND WASHINGTON	

BUREAU V. S.

RECEIVED

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS DOCUMENT. ANY PERSON WHOSE NAME IS ON THIS DOCUMENT IS REQUESTED TO REVIEW IT FOR ACCURACY. IF THERE IS A MISTAKE, IT SHOULD BE CORRECTED IMMEDIATELY. THE DEPARTMENT OF HEALTH WILL NOT BE RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN THIS DOCUMENT.

12421

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

COUNTY

WASHINGTON MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWNHagerstown 1 m.
Wash Co. Hospital
Hagerstown, Md

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland 140 WASH COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNHancock Rt #1 x
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

S

8. DATE OF BIRTH:

12-20-55

4. DATE OF DEATH:

(Month)

(Day)

(Year)

12 20 1955

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

1 m.

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

none

10b. KIND OF BUSINESS OR INDUSTRY:

none

11. BIRTHPLACE (State or foreign country):

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

WILLIAM M. HOLLAND

14. MOTHER'S MAIDEN NAME:

Katherine Normallee Socks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

9

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

MRS RALPH MAY LINCOLN Ave
HAGERSTOWN, MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5

Immediate cause

(a)

DUE TO

Congenital Atelectasis

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

1 m.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Immaturity, Fms.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Dec 20, 1955, to Dec 22, 1955, that I last saw the deceased

alive on Dec 20, 1955, and that death occurred at Hagerstown, Md.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Dec 23, 1955 B. H. Bowers ALBERT L. LEAF WILKINSSPORT MARYLAND

20V5252364

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 27 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12416

12422

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Washington Co</i>		MARYLAND		STATE <i>Ind</i>		COUNTY <i>Washington</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Hagerstown Md</i>		<i>10 days</i>		TOWN <i>Williamsport Md. RDI</i>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Co Hospital</i>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>SAMUEL</i> (Middle) <i>L</i> (Last) <i>HORNBAKER</i>				(Month) <i>12</i> (Day) <i>24</i> (Year) <i>1953</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12-30-1876</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Murdersburg Pa RDI</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Henry C. Hornbaker</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Fuler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>162-22-1829</i>		17. INFORMANT & ADDRESS <i>Mrs Geo May Williamsport Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/23/53</i> , to <i>12/24/53</i> , that I last saw the deceased alive on <i>12/24/53</i> , 19 <i>53</i> , and that death occurred at <i>9:50</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Ralph L. Brown</i>		M.D.		ADDRESS (Street, city, town, state) <i>Williamsport Md</i>		DATE SIGNED <i>12/26/53</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <i>12/28/53</i>		NAME OF CEMETERY OR CREMATORY <i>Pine Grove Cemetery</i>		LOCATION (City, town, or county) <i>Murdersburg Pa RDI</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. H. Bowers</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. M. Linger</i>		ADDRESS <i>Murdersburg, Pa</i>	
DATE <i>Dec 26, 1953</i>							

CERTIFICATE OF DEATH

1. SEX: ☐ MALE ☐ FEMALE

2. RACE: ☐ WHITE ☐ NEGRO ☐ OTHER

3. AGE: ☐ 0-1 ☐ 1-4 ☐ 5-9 ☐ 10-14 ☐ 15-19 ☐ 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60-64 ☐ 65-69 ☐ 70-74 ☐ 75-79 ☐ 80-84 ☐ 85-89 ☐ 90-94 ☐ 95-99 ☐ 100+

4. DATE OF BIRTH:

5. PLACE OF BIRTH:

6. OCCUPATION:

7. CAUSE OF DEATH:

8. MANNER OF DEATH:

9. PLACE OF DEATH:

10. SIGNATURE OF DECEASED:

11. SIGNATURE OF WITNESS:

12. SIGNATURE OF PHYSICIAN:

13. SIGNATURE OF CORONER:

14. SIGNATURE OF JUDGE:

15. SIGNATURE OF CLERK:

BUREAU V. 5

DEC 28 1955

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12423

CERTIFICATE OF DEATH

Reg. Dist. No. 12417302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>County</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>10 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural give location) <u>260 South Prospect Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) MARY FRANCES HOWARD		4. DATE (Month) (Day) (Year) OF DEATH: December 24 19 55	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>November 8, 1870</u>
9. AGE last birthday <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Washington County</u>
13. FATHER'S NAME: <u>Henry C. Loose</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Pearson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT & ADDRESS: <u>Mrs. Victor D. Miller Hagerstown, Maryland</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>			<u>3 days</u>
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis</u>			<u>yr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			<u>yr.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 17, 1955</u> , to <u>Dec. 24, 1955</u> , that I last saw the deceased alive on <u>Dec. 24, 1955</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Chas. A. Hoffman</u>		ADDRESS <u>M. D. 224 N. Potomac St. Hagerstown, Md. 17/26</u>	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/27/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	
24. FUNERAL DIRECTOR <u>C. M. Suter & Sons</u>		ADDRESS <u>Hagerstown, Maryland</u>	

RECEIVED

DEC 29 1955

BUREAU V. S.

12424

CERTIFICATE OF DEATH

12418

Reg. Dist. No. 302

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		STATE <u>MARYLAND</u>		COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>		LENGTH OF STAY (in this place) <u>24 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAGERSTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON COUNTY HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>35 CHARLES ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>IRA</u> (First) <u>MARCHEL</u> (Middle) <u>HUTZELL</u> (Last)				4. DATE OF DEATH (Month) <u>DEC.</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9/21/1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLORIST</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB HUTZELL</u>				14. MOTHER'S MAIDEN NAME <u>ALICE M. DUTROW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-3252</u>		17. INFORMANT & ADDRESS <u>MRS. MATTIE L. HUTZELL</u>		<u>HAGERSTOWN MD.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				18. MEDICAL CERTIFICATION <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/30/55</u> to <u>12/5/55</u>, that I last saw the deceased alive on <u>12/5/55</u>, and that death occurred at <u>11:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. J. Young</u>				DATE SIGNED <u>12/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEM.</u>	
24. REC'D BY REGISTRAR <u>12/12/1955</u>				REGISTRAR'S SIGNATURE <u>W. J. Young</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Horment, Hagerstown, Md.</u>	
DATE				ADDRESS			

CERTIFICATE OF DEATH

1954

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX AND AGE AT DEATH

4. OCCUPATION

5. MARITAL STATUS

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. PLACE OF DEATH

11. SEX AND AGE AT DEATH

12. OCCUPATION

13. MARITAL STATUS

14. DATE OF DEATH

15. TIME OF DEATH

16. CAUSE OF DEATH

17. PLACE OF BIRTH

18. PLACE OF DEATH

19. SEX AND AGE AT DEATH

20. OCCUPATION

21. MARITAL STATUS

22. DATE OF DEATH

23. TIME OF DEATH

24. CAUSE OF DEATH

25. PLACE OF BIRTH

26. PLACE OF DEATH

BUREAU V. S.

DEC 14 1955

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

12419

2411 N. Charles Street, Baltimore

12425

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>417 S. Potomac Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Michael</u> (Middle) <u>Wayne</u> (Last) <u>Jenkins</u>	4. DATE OF DEATH	(Month) <u>Dec.</u> (Day) <u>22</u> (Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec. 21, 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> If under 24 hrs. <u>1</u> yr.
11. BIRTHPLACE (State or foreign country) <u>Washington County Hospital</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Maurice Costello</u> <u>Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Jean Lucille Barton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
762.5 Immediate cause	(a) <u>Congenital Atelectasis</u>	<u>36 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Prematurity</u>	<u>36 hrs.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 12/51, 1951, to 12/22, 1955, that I last saw the deceased alive on 12/22, 1955, and that death occurred at 9:55 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Paul Harrison M.D. 518 N. Potomac St. Hagerstown Md 12/23/55

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>12/23/55</u>	<u>Rest Haven Cem.</u>	<u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Dec 23, 1955</u>	<u>Frank H. Bowers</u>	<u>W. J. Norment</u>	<u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12420

12426

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		STATE MARYLAND		COUNTY WASHINGTON			
CITY (If outside corporate limits, write RURAL OR and give nearest town) HAGERSTOWN		LENGTH OF STAY (In this place) LIFE		CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 792 FREDERICK ST.		STREET ADDRESS (If rural give location) 792 FREDERICK ST.					
3. NAME OF DECEASED (First) (Middle) (Last) EVAN LUTHER JONES				4. DATE OF DEATH (Month) (Day) (Year) DEC. 3 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 9/25/1912	9. AGE last birthday 43 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTUARANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHESTER C. JONES				14. MOTHER'S MAIDEN NAME ABBA G. COSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No or unk.) NO		16. SOCIAL SECURITY NO. 217-10-3148		17. INFORMANT & ADDRESS MRS MARY A. JONES HAGERSTOWN MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary artery thrombosis						45 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary arterisclerosis						6 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 14, 1955, to Dec. 3, 1955, that I last saw the deceased alive on Nov. 29, 1955, and that death occurred at 1:00 PM, from the causes and on the date stated above.							
SIGNATURE <i>George Jennings</i>		DATE THEREOF 12/6/55		NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		24. REC'D BY REGISTRAR Dec. 7, 1955		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment</i>		DATE SIGNED 12/5/55	

CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME, RESIDENCE, AND AGE OF DECEASED

2. PLACE OF DEATH

JACOBSON, JACOBSON, JACOBSON

RESIDENCE

RESIDENCE

RESIDENCE

RESIDENCE

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. OCCUPATION

9. MARITAL STATUS

10. RACE

11. BIRTH DATE

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

BUREAU V. E.

DEC 9 1955

RECEIVED

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12421

12427 CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAGERSTOWN</u>		LENGTH OF STAY (in this place) <u>43 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAGERSTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON COUNTY HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>117 S. POTOMAC ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM HENRY JONES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 21 19 55</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (If married, give date) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/31/1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PIT OPERATOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UTILITY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CORNELIUS JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET DOUGHERTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. CORA C. JONES</u>		<u>HAGERSTOWN MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>41 Hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO						<u>5yrs</u>	
STATING UNDERLYING CAUSE LAST. (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 20</u> , 19 <u>55</u> , to <u>Dec. 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 21</u> , 19 <u>55</u> , and that death occurred at <u>11:15 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. T. Layman, M.D.</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>			
DATE <u>Dec. 23, 1955</u>				DATE SIGNED <u>Dec. 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEM.</u>		LOCATION (City, town, or county) (State) <u>WILLIAMSPORT MD.</u>	
24. REC'D BY REGISTRAR <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Wernert</u>		ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

12127

1. NAME OF DECEASED WILLIAM HENRY JONES		2. PLACE OF DEATH WASHINGTON COUNTY HOSPITAL	
3. SEX MALE		4. AGE 45 YRS	
5. RACE WHITE		6. OCCUPATION FARMER	
7. MARITAL STATUS MARRIED		8. DATE OF DEATH DEC 28 1955	
9. TIME OF DEATH 11:00 AM		10. CAUSE OF DEATH CORONARY THROMBOSIS	
11. SIGNATURE OF PHYSICIAN J. H. B. POTOMAC		12. SIGNATURE OF REGISTRAR MARGARET DOUGHERTY	
13. SIGNATURE OF WITNESSES J. H. B. POTOMAC		14. SIGNATURE OF DECEASED WILLIAM HENRY JONES	

BUREAU V. S.

DEC 28 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12428 CERTIFICATE OF DEATH

12422

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		MARYLAND		STATE Penna.		COUNTY Franklin	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hagerstown		6 days		TOWN Rural Mercersburg		75x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital				STREET ADDRESS (If rural give location) Route # 2			
3. NAME OF DECEASED (Type or Print) Dorothy T. Keefer				4. DATE OF DEATH (Month) (Day) (Year) December 16 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 14, 1921	9. AGE last birthday 34 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House keeping		11. BIRTHPLACE (State or foreign country) Franklin Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Waler				14. MOTHER'S MAIDEN NAME Unable To Obtain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 183-12-2203		17. INFORMANT & ADDRESS Ray W. Keefer, Mercersburg Pa. Route 2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Subacute bacterial endocarditis						7 months	
ANTECEDENT CAUSE(S) DUE TO (B) Rheumatic heart disease						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Virus pneumonitis						1 week	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 2, 19 55 , to Dec. 16, 19 55 , that I last saw the deceased alive on Dec 15 19 55 , and that death occurred at 1:45 A. M, from the causes and on the date stated above.							
SIGNATURE Andri Goben Cohen				DATE SIGNED Dec. 16, 1955			
M.D.				ADDRESS (Street, city, town, state) Clear Spring, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-18-1955		NAME OF CEMETERY OR CREMATORY Welsh Run Brethern Cem.		LOCATION (City, town, or county) (State) Franklin Co. Penna.	
24. REC'D BY REGISTRAR Dec. 16, 1955		REGISTRAR'S SIGNATURE W. H. H. Weaver		25. FUNERAL DIRECTOR'S SIGNATURE Harold M. Zimmerman		ADDRESS Greencastle, Pa.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

County of Franklin

MARYLAND

Washington

City of Washington

6 days

Washington

Route 2

Washington Co. Hospital

Decker

1.

Dorothy

24

August 14, 1951

Married

White

Female

U.S.A.

Franklin Co. Penna.

Housekeeping

Housewife

Unable to obtain

Charles Walter

Rev. W. Decker, Carpenter, Route 2

103-12-2503

No

BUREAU V. 2

DEC 19 1955

RECEIVED

12-18-55, John Ben Breckenridge, Franklin Co. Penna.

Burial

12429

CERTIFICATE OF DEATH

Reg. Dist. No. 302.....

12423

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>D. O. A.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural give location) <u>431 Cook Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CATHERINE LOUISE KEMP</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 10 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>May 22, 1887</u>
9. AGE last birthday <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>18</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Leitersburg, Maryland</u>
13. FATHER'S NAME: <u>Fred Hartle</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Hemphill</u>		17. INFORMANT & ADDRESS: <u>Mrs. Victoria E. Hughes Hagerstown, Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>			<u>3 yr</u>
ANTECEDENT CAUSE (B) <u>Diabetes</u>			<u>6 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-15</u> , 1955, to <u>12-10</u> , 1955, that I last saw the deceased alive on <u>12-10</u> , 1955, and that death occurred at <u>8:10</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>A. P. D. D. D.</u>		DATE SIGNED <u>12-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/13/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Leitersburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 12/1955</u>		24. FUNERAL DIRECTOR <u>C. M. Suter & Sons Hagerstown, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED

12430 CERTIFICATE OF DEATH

Reg. Dist. No. 12426

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WASHINGTON</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>WASHINGTON</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAGERSTOWN</u>		TOWN <u>MT. LENA - RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>WASH. Co. Hospital</u>		<u>Boonsboro MD. R. 2</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First)	(Middle)	(Last)	
<u>HARRY EDGAR - KEPHART</u>		<u>DECEMBER 25 - 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUGUST 18 - 1898</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>57-4-7</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>TRUCK FARMER</u>		<u>OWN FARM</u>	<u>FREDERICK COUNTY MD.</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>LUTHER KEPHART</u>		<u>SADIE FORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>No.</u>			
17. INFORMANT & ADDRESS:			
<u>MRS. SADIE KEPHART BOONSBORO MD. R. 2.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>1 wk</u>
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY?	
<u>0</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 17, 1955</u> , to <u>Dec. 25, 1955</u> , that I last saw the deceased alive on <u>Dec. 24, 1955</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.			
SIGNATURE <u>OW Wilson</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>BURIAL</u>		<u>WM. F. BAST AND SONS BOONSBORO MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Chas. R. Howard</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr E.W.Ditto

12431

CERTIFICATE OF DEATH

12425

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03</u> TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>12</u> Hours		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> <u>03</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS <u>419 Linsanore Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>ALLIE</u> (First) <u>BELLE</u> (Middle) <u>KEPLINGER</u> (Last)				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>6</u> (Year) <u>1955</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>November 4 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brownsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John B. Potter</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Deener</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Maynard J. Kelpinger</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>260x</u> IMMEDIATE CAUSE (A) <u>DIABETES</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>6 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Genus Arterio sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-1</u>, 19<u>53</u>, to <u>12-6</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-6</u>, 19<u>55</u>, and that death occurred at <u>12P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. W. Ditto</u>				DATE SIGNED <u>12/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown Wash. Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
DATE <u>Dec 10, 1955</u>				ADDRESS <u>Hagerstown Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

12481 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

12426

Reg. Dist. No. 3023023

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Near Claerspring, Md.</u> LENGTH OF STAY (In this place) <u>Few Min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On Road Near Clearspring, Md.</u>		STREET ADDRESS (If rural, give location) <u>930D Ianvale Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>Earl</u> (Last) <u>Kershner</u>	4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>18</u> (Year) <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 22, 1926</u> 9. AGE last birthday <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rag. Rubber Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>
13. FATHER'S NAME <u>Max Kershner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fryer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes War II</u>		16. SOCIAL SECURITY No. <u>219-14-5108</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Geo. E. Kershner, Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Fractured Skull (Open) hemorrhage and shock</u>	10 min	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>-</u>	20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	(CITY OR TOWN) <u>Rural - Indain Springs, Wash. Md.</u> (COUNTY) <u>Washington</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 18 '55 03:00AM</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Auto accident- Hit a tree head-on</u>

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>J. Robert T. Wells M.D.</u> (Degree or title)		ADDRESS <u>115 N. Potomac St- Hagerstown, Md.</u>	
DATE SIGNED <u>12-19-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12-21-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Dec 20, 1955</u>	REGISTRAR'S SIGNATURE <u>Joseph W. Minnig</u>	24. FUNERAL DIRECTOR <u>C. M. Suter & Sons, Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

DEC 30 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12432

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12427
Reg. Dist.

No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>District of Columbia</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>24 hrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS <u>1331 Fairmont St. N.W.</u>			
3. NAME OF DECEASED: (First) <u>Edwin</u> (Middle) <u>Alderman</u> (Last) <u>King</u>				4. DATE OF DEATH: (Month) <u>12</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 20, 1900</u>	9. AGE last birthday: yrs. <u>55</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Public Roads</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Greenville, N.C.</u>	
13. FATHER'S NAME: <u>George B. King</u>				14. MOTHER'S MAIDEN NAME: <u>Nannie A. King</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>George B. King, Jr. - Richmond, Va.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>904.9</u> Immediate cause (a) <u>(closed) Fractured Skull - hemorrhage and shock</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>60 hrs</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Paget's Disease</u>							
19a. DATE OF OPERATION: <u>3 Dec. 14 '55</u>		19b. MAJOR FINDING OF OPERATION: <u>fractured skull</u> <u>Trephining operation of skull-- Sub dural hemorrhage</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Street</u>		21c. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-11-55 7:00PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Found on street in semi-conscious condition</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>S. J. Ruben & Wells</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-15-55</u> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Greenville, N.C.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>W. H. Hinks</u>		24. FUNERAL DIRECTOR <u>W. H. Hinks</u>		ADDRESS <u>Washington, D.C.</u>	

RECEIVED

DEC 19 1955

BUREAU V. S.

12432

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 305

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BOONSBORO</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BOONSBORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. MAIN ST.</u>				STREET ADDRESS (If rural, give location) <u>N. MAIN ST.</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<u>DWIGHT -</u>		<u>DAVID -</u>		<u>KITCHEN</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>OCT-5-1955</u>	
9. AGE last birthday <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARTINSBURG - W. VA.</u>	
13. FATHER'S NAME <u>NEAL B. KITCHEN</u>		14. MOTHER'S MAIDEN NAME <u>JACQUELYN MORGAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>NEAL B. KITCHEN BOONSBORO MD</u>		18. MEDICAL CERTIFICATION		19. MEDICAL CERTIFICATION		20. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Acute bronchopneumonia</u>				<u>10 hrs.</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>A. Robert Mills M.D.</u>				ADDRESS <u>D.M.E. Wash. Co. Md.</u>		DATE SIGNED <u>Hagerstown, Md 12-19-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>DEC. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
DATE REC'D BY LOCAL REG <u>DEC. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. [Signature]</u>		24. FUNERAL DIRECTOR <u>W.M.F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 22 1955

BUREAU V. S

12433

CERTIFICATE OF DEATH

Reg. Dist. No. 302

12429

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington MARYLAND		STATE Md. COUNTY Wash	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
TOWN Hagerstown		OR TOWN Rural Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital		STREET ADDRESS (If rural give location) Route 5	
3. NAME OF DECEASED: (First) Eliza (Middle) Jane (Last) Kline		4. DATE (Month) (Day) (Year) OF DEATH: Dec. 23 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Jan. 17, 1865
9. AGE last birthday: 90 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0	11. IF UNDER 24 HRS.: Hours 0 Min. 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10B. KIND OF BUSINESS OR INDUSTRY: Home Nursing	
11. BIRTHPLACE (State or foreign country): Frederick County Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Samuel Delauter		14. MOTHER'S MAIDEN NAME: Martha Weddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT & ADDRESS: Mrs. Emma Burkhardt Smithsburg Rt. 2			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET OF DISEASE AND DEATH: 20 yrs	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Pneumonia & Edema			
IMMEDIATE CAUSE (A) Arterio Sclerotic Heart			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arterio Sclerosis 20 yrs			
(C) Generalized Arterio Sclerosis 20 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1, 1955 to Dec 23, 1955 , that I last saw the deceased alive on Dec 23, 1955 , and that death occurred at 9:15 AM , from the causes and on the date stated above.			
SIGNATURE G. A. P. Oiler		ADDRESS M. D. Smithsburg DATE SIGNED 12/23/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-26-55	
NAME OF CEMETERY OR CREMATORY Leitersburg Luthern		LOCATION (City, town, or county) (State) Leitersburg Md.	
DATE REC'D BY LOCAL REGISTRAR Dec. 24, 1955		REGISTRAR'S SIGNATURE Blair H. Bowers	
24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Smithsburg Md.	

BUREAU V. S.

DEC 28 1935

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12434

CERTIFICATE OF DEATH

12430

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		MARYLAND		STATE MARYLAND		COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 03 TOWN HAGERSTOWN		LENGTH OF STAY (In this place) 28 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) 03 TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 1072 S. POTOMAC ST.				STREET ADDRESS (If rural give location) 1 1072 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) EVA AGNES KNODE				4. DATE (Month) (Day) (Year) OF DEATH DEC. 7 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 8/25/1885	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JACOB BENDER				14. MOTHER'S MAIDEN NAME BARBARA JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MISS MILDRED KNODE		HAGERSTOWN MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
421.4 IMMEDIATE CAUSE (A) Acute broncho-pneumonia						8 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Endo-carditis						18yrs	
260x (C) myocarditis						18yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes M						10yrs	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION -				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - -			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -			
22. I hereby certify that I attended the deceased from June, 1937, to Dec. 7, 1955, that I last saw the deceased alive on Dec. 7, 1955, and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
SIGNATURE J. Robert Wells				ADDRESS (Street, city, town, state) DATE SIGNED M.D. 115 N. Potomac St- Hagerstown, Md. 12-9-55			
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 12/10/55		NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY		LOCATION (City, town, or county) (State) SHARPSBURG MD.	
24. REC'D BY REGISTRAR DATE Dec. 12, 1955		REGISTRAR'S SIGNATURE Charles H. Powers		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Verment		ADDRESS Hagerstown, Md.	

CERTIFICATE OF DEATH

Reg. Off. No.

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF SHERIFF

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39. SIGNATURE OF SHERIFF

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF SHERIFF

BUREAU V. 2

DEC 14 1955

RECEIVED

2000-11-18

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12431

12435

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		STATE MARYLAND		COUNTY WASHINGTON			
CITY (If outside corporate limits, write RURAL OR and give nearest town) HAGERSTOWN		LENGTH OF STAY (in this place) 40 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARLOCK MEMORIAL CONV. HOSPITAL		STREET ADDRESS (If rural give location) 205 S. POTOMAC ST.					
3. NAME OF DECEASED (Type or Print) CATHERINE AGNES KUHN				4. DATE OF DEATH (Month) DEC. (Day) 19 (Year) 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State) WIDOWED	8. DATE OF BIRTH 2/12/1876		9. AGE last birthday 79 yrs.	10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CULLEN				14. MOTHER'S MAIDEN NAME MARY McKENNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MISS MARY M. KUHN		HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Hypertensive Cardiac Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Disease				10 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-1-1934, to 12-19-1953, that I last saw the deceased alive on 12-17-1953, and that death occurred at M., from the causes and on the date stated above.							
SIGNATURE <i>J. E. W. Smith</i>				DATE SIGNED <i>12-21-53</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/22/55		NAME OF CEMETERY OR CREMATORY ST. PAULS CHURCH CEM.		LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. REC'D BY REGISTRAR DATE 12/23/1955		REGISTRAR'S SIGNATURE <i>Blair H. Powers</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment</i>			
				ADDRESS <i>Hagerstown, Md.</i>			

CERTIFICATE OF DEATH

1954

DECEASED'S RESIDENCE (HOUSE OR APARTMENT)

PLACE OF DEATH

NAME OF DECEASED

SEX

DATE OF BIRTH

AGE

PLACE OF BIRTH

DECEASED'S OCCUPATION

CAUSE OF DEATH

TIME

DATE

PLACE

SEX

AGE

DATE

PLACE

DECEASED'S RESIDENCE

SEX

DATE OF BIRTH

NAME OF DECEASED

PLACE OF BIRTH

DECEASED'S OCCUPATION

SEX

DATE OF BIRTH

CAUSE OF DEATH

BUREAU V.

DEC 27 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Novenstein

12436 CERTIFICATE OF DEATH

12432

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Hagerstown</u>		8 hr.		TOWN <u>Funkstown,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>215 East Baltimore Street</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLOTTE (NMN) Kuhn</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 29. 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 25, 1952</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred W. Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Bonnie Mick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Fred W. Kuhn</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				12-29-55			
IMMEDIATE CAUSE (A) <u>Convulsive disorder due to unknown cause</u>				12-29-55			
ANTECEDENT CAUSE(S) (B) <u>Cerebral Edema</u>				12-27-55			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Measles - Prodromal stage - Terminal Pneumonia</u>				12-29-55			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 27, 1955</u> , to <u>Dec. 29, 1955</u> , that I last saw the deceased alive on <u>Dec. 29, 1955</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sedney Novenstein</u> M.D.				ADDRESS (Street, city, town, state) <u>Funkstown Md</u> DATE SIGNED <u>12-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/1/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
24. REG'D BY REGISTRAR <u>Jan. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>			

BUREAU V. B.

JAN 5 1956

RECEIVED

12483

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>RURAL-Sharpsburg</u>		<u>Lifetime</u>		TOWN <u>Sharpsburg - Rural</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharpsburg RFD #2</u>				STREET ADDRESS (If Rural give location) <u>Sharpsburg RFD #2</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Katherine</u>		<u>MAYER</u>		<u>Lyne</u>			
4. DATE (Month) (Day) (Year)		OF DEATH: <u>Dec.</u>		<u>20,</u>		<u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>1879</u>	
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>8</u>		Days <u>19</u>		Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Owner</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Sharpsburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Charles Bentz Lyne</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Lemen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				<u>24 hours</u>			
DUE TO							
ANTECEDENT CAUSE (B) <u>Coronary Sclerosis</u>				<u>5 years</u>			
DUE TO							
(C) <u>Hypertensive Heart Disease</u>				<u>5+ years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19..... to <u>Dec 20, 1955</u> that I last saw the deceased alive on <u>Dec 20, 1955</u> , and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <u>H. Wanger</u>		ADDRESS <u>M.D. Shepherdstown W. Va.</u>		DATE SIGNED <u>12/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Shepherdstown, W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 21, 1955</u>		REGISTRAR'S SIGNATURE <u>E. G. Boyer</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edith V. Leaf Williamsport, Md.</u>			

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 9 1956
BUREAU V. S.

12437

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>03</u> TOWN <u>Hagerstown</u>	<u>2</u> years	OR TOWN <u>Hagerstown</u> <u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>119 North Foundry Street</u>		STREET ADDRESS (If rural give location) <u>119 North Foundry Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>JAMES LAWRENCE AUGUSTA MARTIN</u>		<u>December 6 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>April 2, 1894</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>61</u> yrs.		Months <u>8</u> Days <u>4</u> Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Painter</u>		<u>G. M. Gehr & Sons</u>	<u>Big Springs, Maryland</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:	
<u>U.S.A.</u>		<u>John Randolph Martin</u>	
14. MOTHER'S MAIDEN NAME:		15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
<u>Molly Russell</u>		<u>1212-24-3690</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>1212-24-3690</u>		<u>Mrs. Betty McKee Hagerstown, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Mesenteric Thrombosis</u>			<u>1 hr.</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 6 1955</u> to <u>Dec 6 1955</u> , that I last saw the deceased alive on <u>Apr 14, 1938</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Edward H. Welch</u>		DATE SIGNED <u>12/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Rose Hill Cemetery</u>	
DATE THEREOF <u>12/8/1955</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Edward H. Welch</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>C. M. Suter & Sons</u>		<u>Hagerstown, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 9 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12438

CERTIFICATE OF DEATH

12434

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>54 S. Cannon Ave.,</u>			
3. NAME OF DECEASED (Type or Print) <u>Veronica</u> (First) <u>Marie</u> (Middle) <u>Martin</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb. 28, 1889</u>		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Albany, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Laliberte</u>				14. MOTHER'S MAIDEN NAME <u>Veronica Dutrizac</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-4739</u>		17. INFORMANT & ADDRESS <u>Edward Martin Hagerstown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, Diabetes Mellitus - Diabetic Gangrene</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension, Cardiovascular Disease</u>						<u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cholecystitis, Chronic</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
2fa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		2fa. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 19, 1950</u> , to <u>Dec 21, 1955</u> , that I last saw the deceased alive on <u>Dec 21, 1955</u> , and that death occurred at <u>6:00 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR DATE <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md.</u>	

RECEIVED

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 18

15438

1. NAME OF DECEASED Maryland Baltimore		2. PLACE OF DEATH Baltimore	
3. SEX Male		4. AGE 21	
5. OCCUPATION Student		6. MARITAL STATUS Single	
7. DATE OF DEATH Dec 28, 1955		8. TIME OF DEATH 10:00 AM	
9. CAUSE OF DEATH Sudden		10. PLACE OF BIRTH Baltimore	
11. DATE OF BIRTH Dec 7, 1934		12. PLACE OF BIRTH Baltimore	
13. NAME OF FATHER John		14. NAME OF MOTHER Mary	
15. NAME OF PHYSICIAN Dr. J. H. Smith		16. NAME OF HOSPITAL St. Mary's Hospital	
17. NAME OF BURIAL PLACE St. Mary's Cemetery		18. NAME OF FUNERAL HOME St. Mary's Funeral Home	
19. NAME OF MINISTER Rev. J. H. Smith		20. NAME OF CHURCH St. Mary's Church	
21. NAME OF CLERGYMAN Rev. J. H. Smith		22. NAME OF CLERGYMAN Rev. J. H. Smith	
23. NAME OF CLERGYMAN Rev. J. H. Smith		24. NAME OF CLERGYMAN Rev. J. H. Smith	
25. NAME OF CLERGYMAN Rev. J. H. Smith		26. NAME OF CLERGYMAN Rev. J. H. Smith	
27. NAME OF CLERGYMAN Rev. J. H. Smith		28. NAME OF CLERGYMAN Rev. J. H. Smith	
29. NAME OF CLERGYMAN Rev. J. H. Smith		30. NAME OF CLERGYMAN Rev. J. H. Smith	
31. NAME OF CLERGYMAN Rev. J. H. Smith		32. NAME OF CLERGYMAN Rev. J. H. Smith	
33. NAME OF CLERGYMAN Rev. J. H. Smith		34. NAME OF CLERGYMAN Rev. J. H. Smith	
35. NAME OF CLERGYMAN Rev. J. H. Smith		36. NAME OF CLERGYMAN Rev. J. H. Smith	
37. NAME OF CLERGYMAN Rev. J. H. Smith		38. NAME OF CLERGYMAN Rev. J. H. Smith	
39. NAME OF CLERGYMAN Rev. J. H. Smith		40. NAME OF CLERGYMAN Rev. J. H. Smith	
41. NAME OF CLERGYMAN Rev. J. H. Smith		42. NAME OF CLERGYMAN Rev. J. H. Smith	
43. NAME OF CLERGYMAN Rev. J. H. Smith		44. NAME OF CLERGYMAN Rev. J. H. Smith	
45. NAME OF CLERGYMAN Rev. J. H. Smith		46. NAME OF CLERGYMAN Rev. J. H. Smith	
47. NAME OF CLERGYMAN Rev. J. H. Smith		48. NAME OF CLERGYMAN Rev. J. H. Smith	
49. NAME OF CLERGYMAN Rev. J. H. Smith		50. NAME OF CLERGYMAN Rev. J. H. Smith	
51. NAME OF CLERGYMAN Rev. J. H. Smith		52. NAME OF CLERGYMAN Rev. J. H. Smith	
53. NAME OF CLERGYMAN Rev. J. H. Smith		54. NAME OF CLERGYMAN Rev. J. H. Smith	
55. NAME OF CLERGYMAN Rev. J. H. Smith		56. NAME OF CLERGYMAN Rev. J. H. Smith	
57. NAME OF CLERGYMAN Rev. J. H. Smith		58. NAME OF CLERGYMAN Rev. J. H. Smith	
59. NAME OF CLERGYMAN Rev. J. H. Smith		60. NAME OF CLERGYMAN Rev. J. H. Smith	
61. NAME OF CLERGYMAN Rev. J. H. Smith		62. NAME OF CLERGYMAN Rev. J. H. Smith	
63. NAME OF CLERGYMAN Rev. J. H. Smith		64. NAME OF CLERGYMAN Rev. J. H. Smith	
65. NAME OF CLERGYMAN Rev. J. H. Smith		66. NAME OF CLERGYMAN Rev. J. H. Smith	
67. NAME OF CLERGYMAN Rev. J. H. Smith		68. NAME OF CLERGYMAN Rev. J. H. Smith	
69. NAME OF CLERGYMAN Rev. J. H. Smith		70. NAME OF CLERGYMAN Rev. J. H. Smith	
71. NAME OF CLERGYMAN Rev. J. H. Smith		72. NAME OF CLERGYMAN Rev. J. H. Smith	
73. NAME OF CLERGYMAN Rev. J. H. Smith		74. NAME OF CLERGYMAN Rev. J. H. Smith	
75. NAME OF CLERGYMAN Rev. J. H. Smith		76. NAME OF CLERGYMAN Rev. J. H. Smith	
77. NAME OF CLERGYMAN Rev. J. H. Smith		78. NAME OF CLERGYMAN Rev. J. H. Smith	
79. NAME OF CLERGYMAN Rev. J. H. Smith		80. NAME OF CLERGYMAN Rev. J. H. Smith	
81. NAME OF CLERGYMAN Rev. J. H. Smith		82. NAME OF CLERGYMAN Rev. J. H. Smith	
83. NAME OF CLERGYMAN Rev. J. H. Smith		84. NAME OF CLERGYMAN Rev. J. H. Smith	
85. NAME OF CLERGYMAN Rev. J. H. Smith		86. NAME OF CLERGYMAN Rev. J. H. Smith	
87. NAME OF CLERGYMAN Rev. J. H. Smith		88. NAME OF CLERGYMAN Rev. J. H. Smith	
89. NAME OF CLERGYMAN Rev. J. H. Smith		90. NAME OF CLERGYMAN Rev. J. H. Smith	
91. NAME OF CLERGYMAN Rev. J. H. Smith		92. NAME OF CLERGYMAN Rev. J. H. Smith	
93. NAME OF CLERGYMAN Rev. J. H. Smith		94. NAME OF CLERGYMAN Rev. J. H. Smith	
95. NAME OF CLERGYMAN Rev. J. H. Smith		96. NAME OF CLERGYMAN Rev. J. H. Smith	
97. NAME OF CLERGYMAN Rev. J. H. Smith		98. NAME OF CLERGYMAN Rev. J. H. Smith	
99. NAME OF CLERGYMAN Rev. J. H. Smith		100. NAME OF CLERGYMAN Rev. J. H. Smith	

BUREAU V. S.

DEC 28 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12439 **CERTIFICATE OF DEATH**

12435
Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Penna</u>		COUNTY <u>Franklin</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Memorial Home</u>		STREET ADDRESS (If rural give location) <u>65 N. Federal Street</u>					
3. NAME OF DECEASED (Type or Print) <u>Martha L. Miller</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>15</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>11-18-1883</u>	
9. AGE last birthday <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Marion, Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abram L. Horst</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hegge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mrs. Geo. G. Gonder, Jr. Chamb. Pa.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Coronary related Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Aug 1, 1935, to Feb 13, 1955, that I last saw the deceased alive on Dec 1 - 1955, and that death occurred at 2 PM, from the causes and on the date stated above.							
SIGNATURE <u>A. Swartz</u>		M.D. <u>Hagerstown Md</u>		ADDRESS (Street, city, town, state) <u>1716/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Marion Mennonite Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marion, Pa.</u>	
24. REC'D BY REGISTRAR <u>Dec. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sellers Funeral, Chambersburg, Pa.</u>		ADDRESS	

1913 CERTIFICATE OF DEATH

1913

2. DEATH REPORTED (NAME OF PHYSICIAN)

MARYLAND

3. PLACE OF DEATH

1. NAME OF DECEASED	4. SEX	7. AGE
5. OCCUPATION	8. COLOR	9. MARITAL STATUS
6. PLACE OF BIRTH	10. DATE OF BIRTH	11. DATE OF DEATH

12. CAUSE OF DEATH	13. MANNER OF DEATH
14. MEDICAL CERTIFICATION	15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR	17. DATE OF REGISTRATION
18. ADDRESS OF DECEASED	19. ADDRESS OF PHYSICIAN
20. SIGNATURE OF DECEASED	21. SIGNATURE OF WITNESS

BUREAU V. S.

DEC 19, 1935

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Lloyd Hoffman

12440 CERTIFICATE OF DEATH

12436

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Hagerstown</u>		<u>10 Days</u>		TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>909 Hamilton Blvd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MARY</u>		(Middle) <u>EDITH</u>		(Last) <u>MILLER</u>		<u>December 24 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>March 6 1867</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own Home</u>		<u>Fayetteville Pa</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Rev Victor Miller</u>				<u>Mary Cath Spickler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Miss Matilda Miller</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Varicose Ulcers - both legs</u>						<u>2 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 8</u>, 19<u>55</u>, to <u>Dec. 24</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 24</u>, 19<u>55</u>, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Lloyd A. Hoffman</u>				ADDRESS (Street, city, town, state) <u>M.D. 214 N. Potomac St. Hagerstown, Md 17/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-27-55</u>		<u>St Pauls Cemetery near Clear Springs Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec. 27, 1955</u>		<u>L. H. Bowers</u>		<u>Andrew K. Coffman</u>		<u>Hagerstown Md</u>	

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, a Notary Public in and for said State, do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of said County.

BUREAU V. S.

DEC 29 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Case registered
517-100 + W 100-1-100
D.M.E. Records Co. Inc. 12441

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

12437

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md.	COUNTY Wash.
CITY (If outside corporate limits, write RURAL or give nearest town) TOWN Hagerstown	LENGTH OF STAY (in this place) 40 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS (If rural give location) 103 North Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) Mary Leora Minnebraker		4. DATE (Month) (Day) (Year) OF DEATH: Dec. 18, 19 55	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH: April 6, 1877
9. AGE last birthday 78 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife		10B. KIND OF BUSINESS OR INDUSTRY: own home	
11. BIRTHPLACE (State or foreign country): Maugansville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Charles M. Dunahugh		14. MOTHER'S MAIDEN NAME: Martha Rumberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT & ADDRESS: Mrs. Leora Scott, Hagerstown, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 902.0			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Intertrochanteric Fracture l. femur		1 week	
(B) Arteriosclerotic C-V Disease with myocardiopathy		5 yrs +	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21B. PLACE (Home, farm, factory, etc.) OF INJURY Home	
21C. WHERE DID INJURY OCCUR? Home (Hagerstown Md)		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 11 AM on 12 Dec 55		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? fell from chair in run home			
22. I hereby certify that I attended the deceased from 12/12 , 19 55 , to 18 Dec , 19 55 , that I last saw the deceased alive on 18 Dec , 19 55 , and that death occurred at 11:34 AM , from the causes and on the date stated above.			
SIGNATURE J F Lusby		DATE SIGNED 19 Dec 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-20-55	
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown, Md.	
DATE REC'D BY LOCAL REGISTRAR Dec 20, 1955		REGISTRAR'S SIGNATURE Charles H. Bowers	
24. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown		ADDRESS	

BUREAU V. S.

DEC 27 1955

RECEIVED

12442 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown LENGTH OF STAY (In this place) 3 hrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Va. COUNTY Clarke CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berryville 83 x .3 STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) Frederick Holliday Morris			4. DATE (Month) (Day) (Year) OF DEATH: Dec. 25 19 55				
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): divorced	8. DATE OF BIRTH: April 1, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): dealer		10B. KIND OF BUSINESS OR INDUSTRY: farm machinery		11. BIRTHPLACE (State or foreign country): Clarke County, Va.			
13. FATHER'S NAME: John Morris			14. MOTHER'S MAIDEN NAME: Anne M. Enders				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mrs. Idella Whipp, Hagerstown, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction				4 hrs			
ANTECEDENT CAUSE (S) (B) Arteriosclerotic Heart Disease				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/25 , 19 55 , to 12/25 , 19 55 , that I last saw the deceased alive on 12/25 , 19 55 , and that death occurred at 5:50 P M, from the causes and on the date stated above.							
SIGNATURE Dalton M. Welty		ADDRESS Hagerstown		DATE SIGNED 12/25/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-28-55		NAME OF CEMETERY OR CREMATORY Green Hill Cemetery LOCATION (City, town, or county) (State) Berryville, Va.			
DATE REC'D BY LOCAL REGISTRAR Dec. 25, 1955		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son, Hagerstown			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

12443 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
03 TOWN <u>Hagerstown</u>	30 years	TOWN <u>Hagerstown</u> 03	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1134 Potomac Ave.</u>		STREET ADDRESS (If rural give location) <u>1134 Potomac Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
MERTIE EDITH MOSER		December 5 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: October 23, 1875
9. AGE last birthday 80 yrs.		IF UNDER 1 YEAR: Months 1 Days 12 Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Frederick County Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Alfred Frey		14. MOTHER'S MAIDEN NAME: Mary Elizabeth Renner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT & ADDRESS: Mrs. Leona B. Humelsine Hagerstown, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease DUE TO			
ANTECEDENT CAUSE (S) (B) Arteriosclerosis DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes mellitus			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 1952, to Dec. 5, 1955, that I last saw the deceased alive on Dec. 4, 1955, and that death occurred at 5 P. M. from the causes and on the date stated above.			
SIGNATURE <u>Phyllis A. Hoffman</u>		ADDRESS <u>M. D. 214 N. Potomac St.</u>	
DATE SIGNED <u>12/6/55</u>		M.D. <u>md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE TIME OF <u>12/6/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Evangelical United Brethren Cemetery</u>		LOCATION (City, town, or county) (State) <u>Myersville Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	
24. FUNERAL DIRECTOR <u>C. M. Suter & Sons</u>		ADDRESS <u>Hagerstown, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 9 1955

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12484

CERTIFICATE OF DEATH

12440

Reg. Dist. No. 304

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Hancock Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hancock Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>151 E. Main St Hancock Md.</u>		STREET ADDRESS (If rural, give location) <u>151 E. Main St Hancock Md.</u>	
3. NAME OF DECEASED (First) <u>Mollie</u> (Middle) <u>Viola</u> (Last) <u>Myers</u>	4. DATE OF DEATH (Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12.9.1878</u>
9. AGE last birthday <u>77</u> yrs.		10. If under 1 year Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otha Shives</u>		14. MOTHER'S MAIDEN NAME <u>Dorothe Trumppower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Dolly M Deneen 151 E. Main St Hancock Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>450.0</u>		<u>Malnutrition</u> <u>over 3 weeks</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		<u>Arteriosclerosis</u> <u>10 yr</u>
(c) <u>Fractured R. Femur</u>		<u>4 yr</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1930, 19....., to Dec 9, 1955, that I last saw the deceased alive on Dec 9, 1955, and that death occurred atm., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12-19-55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal Cemetery</u>	LOCATION (City, town, or county) <u>Hancock Washington Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>12-19-55</u>	REGISTRAR'S SIGNATURE <u>J. A. Keller</u>	24. FUNERAL DIRECTOR <u>Howard J. Stone</u>	ADDRESS <u>Hancock Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12444

CERTIFICATE OF DEATH

12441

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>Hagerstown #2</u>	
3. NAME OF DECEASED (Type or Print) <u>George A. Patterson</u>		4. DATE OF DEATH <u>Dec. 31, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 15, 1917</u>
9. AGE last birthday <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Emma M. Patterson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>204 04 3996</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Helen Patterson Hagerstown Rte 2</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Thrombosis (left side)</u>		<u>8 days</u>	
Antecedent cause(s) (b) <u>None</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>2/4/56</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input checked="" type="checkbox"/> <u>No</u> <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Dec</u> , 19 <u>55</u> , to <u>31 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 Dec</u> , 19 <u>55</u> , and that death occurred at <u>11:59 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J F Lusby MD</u>		DATE SIGNED <u>2 Jan 56</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		LOCATION (City, town, or county) (State) <u>Mt. Alto, Franklin Pa.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 3, 1956</u>		REGISTERAR'S SIGNATURE <u>Charles Gowers</u>	
24. FUNERAL DIRECTOR <u>Walter J. Love</u>		ADDRESS <u>Waynesboro Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. E.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Cohen

12442

12485 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Clearsprings</u>		<u>50 Yrs</u>		TOWN <u>Clearsprings</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St</u>				STREET ADDRESS (If rural give location) <u>Main St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>GEORGE THOMAS PRATHER</u>				<u>Dec 26 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 14 1866</u>	
9. AGE last birthday <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Clearsprings Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perry T. Prather</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Dr Perry F. Prather</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0</u> <u>CORONARY ARTERY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						NONE	
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>XXXXXXX</u> <u>DEC 26</u>, 19<u>55</u>, that I last saw the deceased <u>DEAD</u> on <u>DEC. 26</u>, 1955, and that death occurred at <u>11-25 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Andrew K. Coffman</u>		M.D.		ADDRESS (Street, city, town, state) <u>CLEAR SPRING, MARYLAND</u>		DATE SIGNED <u>DEC. 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery near Clear Springs Wash. Co</u>		LOCATION (City, town, or county) <u>Md.</u> (State)	
24. REC'D BY REGISTRAR <u>Dec 31-55</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DEATH CERTIFICATE OF DEATH

1. DEATH RECORDING NUMBER OR DISPOSITION

2. NAME OF DECEASED
 LAST NAME FIRST NAME MIDDLE NAME
 SEX AGE DATE OF BIRTH
 RACE COLOR RELIGION
 PLACE OF BIRTH
 PLACE OF DEATH

3. DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

4. CAUSE OF DEATH
 IMMEDIATE CAUSE
 UNDERLYING CAUSE
 MANNER OF DEATH

5. PLACE OF DEATH
 HOME
 HOSPITAL
 NURSING HOME
 OTHER

6. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

7. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

8. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

9. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

10. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES

BUREAU V. S.

JAN 5 1956

RECEIVED

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred. The local health officer is to be notified of the death of the deceased by the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred. The local health officer is to be notified of the death of the deceased by the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred.

12445 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown Md.</u>		<u>30 DAYS</u>		TOWN <u>Hagerstown Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>233 Belview Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Henry Lansing Preston</u>				<u>Dec. 22, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>July 20 1881</u>	<u>74</u> yrs.	Months <u>5</u>	Days <u>1</u>	Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired Labor</u>				<u>Junk Dealer</u>		<u>Williamsport Md.</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>USA</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Samuel Preston</u>				<u>Mary Reeder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>220-09-9251</u>		<u>Mr. Issac Preston Williamsport Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myasthenia gravis</u>						<u>18 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>Dec. 7, 1955</u>				<u>Inguinal hernia, direct</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>About 15 years, 12/22/55</u> , that I last saw the deceased alive on <u>Dec 22, 1955</u> , and that death occurred at <u>11:10 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Keenan</u>				ADDRESS <u>100 Professional Arts Bldg</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 26-55</u>		<u>Riverview Cemetery</u>		<u>Williamsport Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 24, 1955</u>		<u>Edith V. Leaf</u>		<u>Edith V. Leaf</u>		<u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

DAY 2

BUREAU V. S.

DEC 28 1955

RECEIVED

12446

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

COUNTY WASHINGTON

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

03 HAGERSTOWN

LENGTH OF STAY (in this place)

8 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

81 WASH. CO. HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND. COUNTY WASHINGTON

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN MAPLEVILLE X

STREET ADDRESS (If rural give location)

MAIN ST. /

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CLARA

MAE

REESE

4. DATE (Month)

(Day)

(Year)

OF

DEATH:

DECEMBER-10-1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY:

OWN HOME

11. BIRTHPLACE (State or foreign country):

HAGERSTOWN WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

CHARLES E. MARKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

2/NO.

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS:

HOWARD E. REESE MAPLEVILLE MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

584X

IMMEDIATE CAUSE

(A)

DUE TO

acute Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

4 8 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

Cholelithiasis & Hernia

(C)

Cholelithiasis & Hernia

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

Dec 7/1955

19B. MAJOR FINDINGS OF OPERATION:

Cholelithiasis & Hernia

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1955, to Dec 10, 1955, that I last saw the deceased alive on Dec 10, 1955, and that death occurred at 5:40 M, from the causes and on the date stated above.

SIGNATURE

H. G. K. Miller

ADDRESS

M. D.

Smithsburg Md

DATE SIGNED

12/10/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

DEC. 13, 1955

NAME OF CEMETERY OR CREMATORY

CHURCH OF THE BROTHERS CEMETERY

LOCATION (City, town, or county)

BEAVER CREEK MD

DATE REC'D BY LOCAL REGISTRAR

Dec 12, 1955

REGISTRAR'S SIGNATURE

H. G. K. Miller

24. FUNERAL DIRECTOR

W. F. BAST AND SONS BOONSBORO MD

ADDRESS

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 14 1955

BUREAU V. S.

12445

12447 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03</u> TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>3</u> years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>06</u> <u>411 Reynolds Ave.</u>				STREET ADDRESS (If rural give location) <u>411 Reynolds Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JACOB</u>		(Middle) <u>FRANKLIN</u>		(Last) <u>REID</u>		(Month) (Day) (Year) <u>December 11</u> , 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 21, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 Year Months <u>5</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>55</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. City Park</u>		11. BIRTHPLACE (State or foreign country) <u>Benevola, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob R. Reid</u>				14. MOTHER'S MAIDEN NAME <u>Helen Artz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>723-12-9247</u>		17. INFORMANT & ADDRESS <u>Mrs. Amelia Reid Hagerstown, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X</u> IMMEDIATE CAUSE (A) <u>Carcinoma Pancreas</u>						<u>6 mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-15-1955</u> , to <u>12-11-1955</u> , that I last saw the deceased alive on <u>12-11-1955</u> , and that death occurred at <u>7A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. M. Suter</u>		M.D. <u>Hagerstown</u>		ADDRESS (Street, city, town, state) <u>13143</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/14/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Suter & Sons</u> ADDRESS <u>Hagerstown, Maryland</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1955 CERTIFICATE OF DEATH

Reg. Ord. No. 30

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF REGISTRAR

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60. SIGNATURE OF REGISTRAR

61. SIGNATURE OF REGISTRAR

BUREAU V. 2

DEC 14 1955

RECEIVED

NOTARY PUBLIC

STATE OF MARYLAND, COUNTY OF BALTIMORE, I, the undersigned, Notary Public, do hereby certify that the foregoing is a true and correct copy of the original Certificate of Death filed in my office on this 14th day of December, 1955.

NOTARY PUBLIC

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12448 **CERTIFICATE OF DEATH**

12446

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		STATE MARYLAND		COUNTY WASHINGTON			
CITY (If outside corporate limits, write RURAL OR end give nearest town) HAGERSTOWN		LENGTH OF STAY (in this place) 10 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL		STREET ADDRESS (If rural give location) 46 S. CANNON AVE.					
3. NAME OF DECEASED (First) (Middle) (Last) ALICE MATILDA RHODES				4. DATE OF DEATH (Month) (Day) (Year) DEC. 13 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (S) MARRIED	8. DATE OF BIRTH 5/21/1909	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LEATHER WORKER		10b. KIND OF BUSINESS OR INDUSTRY HAG. LEATHER CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME D. LESLIE BURKETT				14. MOTHER'S MAIDEN NAME GRACE WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, NO or unk.) NO		16. SOCIAL SECURITY NO. 203-10-4989		17. INFORMANT & ADDRESS MR. GEORGE F. RHODES		HAGERSTOWN RT. #3 MD.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170x IMMEDIATE CAUSE (A) Carcinomatosis				unknown			
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of the breast, right				18 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION July 1, 1954		19b. MAJOR FINDINGS OF OPERATION Carcinoma of the breast, right		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) June 28 54		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 13 55 to Dec. 13 55, that I last saw the deceased alive on Dec. 13 55, and that death occurred at 12-25 PM, from the causes and on the date stated above.							
SIGNATURE <i>Robert Cohen</i> M.D.				DATE SIGNED 12-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF 12/15/55		LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. REC'D BY REGISTRAR DATE Dec 16 1955		REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Normant</i>		ADDRESS <i>Hagerstown, Md.</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

JOHN H. BARNES, JR.

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. DATE OF DEATH

15. TIME OF DEATH

16. PLACE OF INTERMENT

17. NAME OF FUNERAL HOME

18. NAME OF CEMETERY

19. NAME OF MINISTER OF THE GOSPEL

20. NAME OF PHYSICIAN

21. NAME OF REGISTRAR

22. NAME OF WITNESSES

23. NAME OF DECEASED

BUREAU V. S.

DEC 19 1955

RECEIVED

ST. PAUL'S CATHEDRAL

BUNIA

RECEIVED

12447

MARYLAND STATE DEPARTMENT OF HEALTH

12449

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 712 MEDWAY RD.		STREET ADDRESS (If rural, give location) 712 MEDWAY RD.	
3. NAME OF DECEASED (Type or Print)	(First) JUDY	(Middle) ANN	(Last) RICKETT
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, (Specify) SINGLE	8. DATE OF BIRTH 1/22/1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY INFANT	9. AGE last birthday 11 yrs. DEC. 15 19 55
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NORMAN RICHARD RICKETT		14. MOTHER'S MAIDEN NAME PHYLLIS NAZELROD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS MR. NORMAN R. RICKETT		HAGERSTOWN MD.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute broncho-pneumonia		12/hre
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Measles	
--	--

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
---------------------------------------	--	---

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY none	(CITY OR TOWN) -	(COUNTY) -	(STATE) -
TIME (Month) (Day) (Year) (Hour) OF INJURY none	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? -		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>S. Robert Wells, M.D.</i>	DEPUTY MEDICAL EXAMINER WASH. CO., MD.	DATE SIGNED 12-16-55
---	--	--------------------------------

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 12/17/55	NAME OF CEMETERY OR CREMATORY East Haven Cemetery	LOCATION (City, town, or county) Hagerstown	(State) MD.
--	------------------------------	--	--	--------------------

DATE REC'D BY LOCAL REG. DEC. 16, 1955	REGISTRAR'S SIGNATURE <i>W. J. Norman</i>	24. FUNERAL DIRECTOR W. J. Norman	ADDRESS Hagerstown, Md.
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

205191415

BUREAU V. S.

DEC 19 1965

RECEIVED

12450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448
Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>				TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CITY JAIL</u>				STREET ADDRESS (If rural, give location) <u>418 W. Antietam St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>James Ralph Robinson</u>				<u>Dec. 10 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>male</u>		<u>white</u>		<u>married</u>		<u>Apr. 22, 1918</u>	
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?			
<u>37</u> yrs.		<u>Mercersburg, Penna.</u>		<u>Mercersburg, Penna.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Bishop Robinson</u>				<u>Bessie Mae Straley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>yes</u>		<u>WW II</u>		<u>204-01-9763 Bishop Robinson, Mercersburg, Penna.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
<u>974X</u>					
Immediate cause		(a) DUE TO			
<u>Asphyxia by hanging</u>					
Antecedent cause(s)		(b) DUE TO			
<u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>12-10-55-9:38 P.M.</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec. 10-55</u>			
<u>S. Robert Wells</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>burial</u>		<u>12-13-55</u>		<u>Fairview Cemetery</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS			
<u>Mercersburg, Penna.</u>		<u>Scott F. Minnich & Son, Hagerstown</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
<u>Dec. 12, 1955</u>		<u>W. H. Bowers</u>			

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12486 CERTIFICATE OF DEATH

Reg. Dist. No. 12449 303

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	WASHINGTON	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	CLEAR SPRING	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	CLEAR SPRING
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MULBERRY ST	STREET ADDRESS (If rural give location)	MULBERRY ST.
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	JOSEPH	OF DEATH:	12 15 19 55
(Middle)	ROBINSON		
(Last)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
MALE	WHITE	WIDOWER	JUNE 15, 1875
9. AGE last birthday		10. IF UNDER 1 YEAR	
80 yrs.		Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
LABOR		FARM	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
ADAM G. ROBINSON		MARY C. UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		NONE	
17. INFORMANT & ADDRESS:		CHARLES ROBINSON RT 1 CLEAR SPRING	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Sudden.	
500 X IMMEDIATE CAUSE (A) DUE TO		Coronary Thrombosis	
ANTECEDENT CAUSE (B) DUE TO		Acute Bronchitis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		2 days	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 14, 1955, to Dec. 15, 1955, that I last saw the deceased alive on Dec. 14, 1955, and that death occurred at 1 P. M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
David R. Brewer		12/16/55	
M. D.		Clear Spring Md	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		12/17/55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
ST PAULS CEMETERY		CLEAR SPRING, MD.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
Dec 16 - 1955 Joseph W. Munnay		ADRIAN H. ROWLAND	
ADDRESS		CLEAR SPRING	

BUREAU V. S.

DEC 18 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12451

CERTIFICATE OF DEATH

12450

302

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03</u> TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>62 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>330 N. Mulberry St.,</u>				STREET ADDRESS (If rural give location) <u>330 N. Mulberry St.,</u>			
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>H</u> (Middle) <u>Rohrer</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 30, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired caretaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>City Park</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Rohrer</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Domer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-28-8872</u>		17. INFORMANT & ADDRESS <u>William H. Rohrer Hagerstown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>arterio sclerotic Heart Disease with</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs +</u>	
ANTECEDENT CAUSE(S) (B) <u>myocardial failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>none</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u> , to <u>Dec 21, 1955</u> , that I last saw the deceased alive on <u>20 Dec 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F. J. Rusby</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

18151

1. NAME OF DECEASED

2. SEX OF DECEASED

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. PLACE OF BIRTH

15. DATE OF BIRTH

16. SEX OF DECEASED

17. CAUSE OF DEATH

18. MANNER OF DEATH

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF WITNESSES

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX OF DECEASED

28. CAUSE OF DEATH

29. MANNER OF DEATH

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF REGISTRAR

32. SIGNATURE OF WITNESSES

33. DATE OF DEATH

34. TIME OF DEATH

35. PLACE OF DEATH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. SEX OF DECEASED

39. CAUSE OF DEATH

40. MANNER OF DEATH

41. SIGNATURE OF PHYSICIAN

42. SIGNATURE OF REGISTRAR

43. SIGNATURE OF WITNESSES

44. DATE OF DEATH

45. TIME OF DEATH

46. PLACE OF DEATH

47. PLACE OF BIRTH

48. DATE OF BIRTH

49. SEX OF DECEASED

50. CAUSE OF DEATH

51. MANNER OF DEATH

52. SIGNATURE OF PHYSICIAN

53. SIGNATURE OF REGISTRAR

54. SIGNATURE OF WITNESSES

BUREAU V. 2

DEC 28 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12451

12452 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		STATE <u>MARYLAND</u>		COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR give nearest town) <u>03</u> <u>HAGERSTOWN</u>		LENGTH OF STAY (If in this place) <u>35 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>03</u> <u>HAGERSTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81</u> <u>WASHINGTON COUNTY HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>109 1/2 W. FRANFLIN ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>DOROTHY</u> (First) <u>KATHRYN</u> (Middle) <u>RUBECK</u> (Last) <u>(DOYLE)</u>				4. DATE OF DEATH (Month) <u>DEC.</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>11/24/1880</u>	9. AGE last birthday <u>75 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM BEAR</u>				14. MOTHER'S MAIDEN NAME <u>LEVERNA ROBEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MR. RALPH RUBECK</u> <u>HAGERSTOWN MD.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 Day</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/25/55</u> to <u>12/26/55</u>, that I last saw the deceased alive on <u>12/26/55</u>, and that death occurred at <u>3:40 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Edwin F. Young</u> M.D.				ADDRESS (Street, city, town, state) <u>W. J. Norment, Hagerstown, Md.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAGERSTOWN, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Edwin F. Young</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment, Hagerstown, Md.</u>			

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. 2

6 1956

RECEIVED

1. NAME OF DECEASED JOHN E. HARRIS JR.		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. DATE OF BIRTH 11/24/1930		4. SEX MALE	
5. OCCUPATION NONE		6. MARITAL STATUS MARRIED	
7. PLACE OF DEATH BALTIMORE, MARYLAND		8. CAUSE OF DEATH CORONARY THROMBOSIS	
9. DATE OF DEATH 12/15/1955		10. TIME OF DEATH 11:00 AM	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESS (None)	
13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF MORTUARY (None)	
15. SIGNATURE OF REGISTRAR (None)		16. SIGNATURE OF CLERK (None)	

DEATH CERTIFICATE

DR. WELLS

MARYLAND STATE DEPARTMENT OF HEALTH

12453

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

12452

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BROWNSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASH. CO. HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>MAIN ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>LEWIS</u>	<u>W.</u>	<u>SEALOCK</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT-12-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9. AGE last birthday <u>75-3-9</u> yrs.
13. FATHER'S NAME <u>CLAYTON SEALOCK</u>		11. BIRTHPLACE (State or foreign country) <u>FREDERICK CO. MD.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>220-09-9180-A</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA WARD</u>	
17. INFORMANT AND ADDRESS <u>MRS. NAOMI POOLE BROWNSVILLE MD.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
442X Immediate cause (a) <u>arterio sclerotic myocardial heart disease</u>		5 yrs
Antecedent cause(s) (b) <u>with myocardial failure grade iv</u>		
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Vascular hypertension</u>		
Chr. Glomerular nephritis		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR? <u>-</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Dr. Robert Wells M.D.</u>		DATE SIGNED <u>Dec. 23 '55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>DEC. 24-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>CHURCH OF THE BRETHREN CEMETERY - BROWNSVILLE MD.</u>		LOCATION (City, town, or county) (State) <u>MD.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 23, 1955</u>		24. FUNERAL DIRECTOR <u>WM. F. BAST AND SONS BOWNSBORO MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

DEC 17 1955

RECEIVED

12457 CERTIFICATE OF DEATH

12453

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Clearspring		LENGTH OF STAY (in this place) 7 months		CITY (If outside corporate limits, write RURAL and give nearest town) Clearspring			
TOWN Clearspring				TOWN Clearspring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street				STREET ADDRESS (If rural give location) Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Russell		(Middle) Clay		(Last) Seibert		(Month) 12 (Day) 17 (Year) 19 55	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Dec. 31, 1891	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tube finisher		10b. KIND OF BUSINESS OR INDUSTRY Fairchilds		11. BIRTHPLACE (State or foreign country) Franklin County, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Seibert				14. MOTHER'S MAIDEN NAME Cora Seiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 212-14-6806		17. INFORMANT & ADDRESS Mrs. Helen Hull Clearspring, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 212-14-6806		17. INFORMANT & ADDRESS Mrs. Helen Hull Clearspring, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				unknown			
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 11, 1955 , to Dec. 17, 1955 , that I last saw the deceased alive on Dec. 16, 1955 , and that death occurred at 5.35a M, from the causes and on the date stated above.							
SIGNATURE Carli Robert Cohen M.D.				ADDRESS (Street, city, town, state) Clear Spring, Md.		DATE SIGNED 12-18-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-20-55		NAME OF CEMETERY OR CREMATORY St. Pauls		LOCATION (City, town, or county) (State) Western Pike Hagerstown, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Joseph W. Munay		25. FUNERAL DIRECTOR'S SIGNATURE Adrian H. Rowland		ADDRESS Rural	
DATE Dec 19-1955							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

12-33

Birth Date: 12-33

Signature of Physician or Health Officer

Signature of Registrar

Signature of Coroner

Signature of

Signature of

38

17

12

12-33

12-33

12-33

12-33

63

Dec. 31, 1911

Dec. 31, 1911

Dec. 31, 1911

Dec. 31, 1911

Signature of Registrar

Signature of

Signature of

Signature of

Signature of

Signature of Registrar

Signature of

Signature of

Signature of

BUREAU V. S.

DEC 30 1955

RECEIVED

Signature of Registrar

Signature of

Signature of

Signature of

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12454
12438 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Hagerstown</u> STREET ADDRESS (If rural give location) <u>Route 2</u>	
3. NAME OF DECEASED: (First) <u>Turner</u> (Middle) <u>Dolan</u> (Last) <u>Shenk</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Dec 2 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 9, 1884</u>
9. AGE last birthday: <u>71</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country): <u>Luray Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas D. Shenk</u>		14. MOTHER'S MAIDEN NAME: <u>Annabelle Batman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-10-7358</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Lucy V. Shenk</u>		<u>Hag. Rt. 2</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>10 min.</u>
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic Heart Disease with</u>			<u>7 yrs.</u>
DUE TO <u>Coronary Sclerosis</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 7, 1955</u> to <u>Dec. 2, 1955</u> , that I last saw the deceased alive on <u>Nov. 7, 1955</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>B. B. [Signature]</u>		ADDRESS <u>M. D. Hagerstown, Md.</u> DATE SIGNED <u>Dec. 5, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-6-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Broadfording Cemetery</u>		LOCATION (City, town, or county) (State) <u>Broadfording Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hag. Md.</u>	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Kohl 12455

12439 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chewsville</u>		LENGTH OF STAY (in this place) <u>30 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chewsville-Leitersburg Road</u>				STREET ADDRESS (If rural give location) <u>Chewsville-Leitersburg Road</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>WALTER</u> (Middle) <u>SHILLING</u> (Last)				4. DATE OF DEATH <u>Dec 30 1955</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Dec 7 1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Father- Owner Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chewsville Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John H. Shilling</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Paul U. Shilling</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Pericardial Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arterio Sclerosis</u>						<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 15, 1955, to Dec 30, 1955, that I last saw the deceased alive on Dec 30, 1955, and that death occurred at 11 P.M. from the causes and on the date stated above.							
SIGNATURE <u>E. G. J. O'Leary</u>		M.D. <u>Smithsburg Md</u>		ADDRESS (Street, city, town, state) <u>Smithsburg Wash. Co. Md</u>		DATE SIGNED <u>1/2/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithsburg Wash. Co. Md</u>	
24. REC'D BY REGISTRAR <u>Jan. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Paul H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

1. LOCAL RESIDENCE OF DECEASED

MARYLAND

COUNTY OF BALTIMORE

TOWN OF BALTIMORE

WARD OF BALTIMORE

STREET OF BALTIMORE

WATER STREET

APARTMENT 101

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12454 CERTIFICATE OF DEATH

12570

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>20yrs.</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>432 Cook Street</u>				STREET ADDRESS (If rural give location) <u>432 Cook Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lulu Orpha Sivits</u>				<u>Dec. 31 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Jan. 6, 1891</u>	<u>64 yrs.</u>	Months <u>11</u>	Days <u>5</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Hagerstown, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Shantz, Sr.</u>				<u>Bessie Linebaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 NO</u>		<u>NONE</u>		<u>Geo. Shantz, Hagerstown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>						<u>6 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1949</u>, to <u>Dec. 31, 1955</u>, that I last saw the deceased alive on <u>Dec. 31, 1955</u>, and that death occurred at <u>8:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert C. Conrad, M.D.</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>1-3-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan. 4, 1956</u>		REGISTRAR'S SIGNATURE <u>Shantz Power</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Suter & Sons, Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF PRISONER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF CLERK

24. SIGNATURE OF DEPUTY CHIEF CLERK

25. SIGNATURE OF RECORDS CLERK

26. SIGNATURE OF CLERK OF THE COURT

27. SIGNATURE OF CLERK OF THE DISTRICT COURT

28. SIGNATURE OF CLERK OF THE COUNTY COURT

29. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT

30. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT

31. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT

32. SIGNATURE OF CLERK OF THE FINANCIAL DEPARTMENT

33. SIGNATURE OF CLERK OF THE AGRICULTURAL DEPARTMENT

34. SIGNATURE OF CLERK OF THE INDUSTRIAL DEPARTMENT

35. SIGNATURE OF CLERK OF THE COMMERCE DEPARTMENT

36. SIGNATURE OF CLERK OF THE TRANSPORTATION DEPARTMENT

37. SIGNATURE OF CLERK OF THE MARITIME DEPARTMENT

38. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

39. SIGNATURE OF CLERK OF THE NAVY DEPARTMENT

40. SIGNATURE OF CLERK OF THE ARMY DEPARTMENT

41. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

42. SIGNATURE OF CLERK OF THE NAVY DEPARTMENT

43. SIGNATURE OF CLERK OF THE ARMY DEPARTMENT

44. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

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50. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

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53. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

54. SIGNATURE OF CLERK OF THE NAVY DEPARTMENT

55. SIGNATURE OF CLERK OF THE ARMY DEPARTMENT

56. SIGNATURE OF CLERK OF THE AIR FORCE DEPARTMENT

57. SIGNATURE OF CLERK OF THE NAVY DEPARTMENT

58. SIGNATURE OF CLERK OF THE ARMY DEPARTMENT

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12490

CERTIFICATE OF DEATH

Reg. Dist. No.

12456

306

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Wash.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u>	LENGTH OF STAY (in this place) <u>41 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cavetown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Mary</u>	(Middle) <u>Ellen</u>	(Last) <u>Snyder</u>	<u>Dec. 19 19 55</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 20, 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Cavetown, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Daniel Waltz</u>		14. MOTHER'S MAIDEN NAME: <u>Clara Poffenberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Harry C. Snyder, Cavetown, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease</u>			<u>6 yrs</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>			<u>6 yrs</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. WHILE <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1949</u> , to <u>Dec 19, 1955</u> , that I last saw the deceased alive on <u>Dec 18, 1955</u> , and that death occurred at <u>4:15 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Robert P. Courad</u>		ADDRESS <u>M. D. Hagerstown, Md</u>	
DATE SIGNED <u>12-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 23-55</u>		REGISTRAR'S SIGNATURE <u>Geo H. Ferguson</u>	
24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son, Smithsburg</u>		ADDRESS	

BUREAU

DEC 28

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12431

CERTIFICATE OF DEATH

12457

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Boonsboro		3 yrs.		TOWN Boonsboro		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Reeder Nursing Home				STREET ADDRESS (If rural give location) Main			
3. NAME OF DECEASED (First) (Middle) (Last) Emma Spielman				4. DATE OF DEATH (Month) (Day) (Year) 12 29 19 55			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Sept. 9, 1880		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Troy Laundry		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Spielman				14. MOTHER'S MAIDEN NAME Margaret McCrory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-6630		17. INFORMANT & ADDRESS Mrs. Harlan Thum Hagerstown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Generalized arterio sclerosis							
ANTECEDENT CAUSE(S) DUE TO (B) Arterio sclerotic myocardial heart disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Osteoarthritis deformans							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) none		21e. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -			
22. I hereby certify that I attended the deceased from Family Dr. Gerald Levan - out of town 19 to 19 that I last saw the deceased alive on 19 and that death occurred at 1:20AM from the causes and on the date stated above.							
SIGNATURE S. Koller Amells				ADDRESS (Street, city, town, state) M.D. 115 N. Potomac St- Hagerstown, Md.		DATE SIGNED 12-30-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-31-55		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. REC'D BY REGISTRAR DATE Jan 1, 1956		REGISTRAR'S SIGNATURE John A. Baird		25. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Race

6. Usual residence at date of death

7. Cause of death

8. Date of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of medical examiner

14. Signature of coroner

15. Signature of funeral director

16. Signature of health officer

17. Signature of registrar

18. Signature of informant

19. Signature of medical examiner

20. Signature of coroner

21. Signature of funeral director

22. Signature of health officer

23. Signature of registrar

24. Signature of informant

25. Signature of medical examiner

26. Signature of coroner

27. Signature of funeral director

28. Signature of health officer

29. Signature of registrar

30. Signature of informant

31. Signature of medical examiner

32. Signature of coroner

33. Signature of funeral director

34. Signature of health officer

35. Signature of registrar

36. Signature of informant

37. Signature of medical examiner

38. Signature of coroner

39. Signature of funeral director

40. Signature of health officer

41. Signature of registrar

42. Signature of informant

43. Signature of medical examiner

44. Signature of coroner

45. Signature of funeral director

46. Signature of health officer

47. Signature of registrar

48. Signature of informant

49. Signature of medical examiner

50. Signature of coroner

49. Signature of funeral director

50. Signature of health officer

51. Signature of registrar

50. Signature of informant

51. Signature of medical examiner

52. Signature of coroner

51. Signature of funeral director

52. Signature of health officer

53. Signature of registrar

52. Signature of informant

53. Signature of medical examiner

54. Signature of coroner

53. Signature of funeral director

54. Signature of health officer

55. Signature of registrar

54. Signature of informant

55. Signature of medical examiner

56. Signature of coroner

55. Signature of funeral director

56. Signature of health officer

57. Signature of registrar

56. Signature of informant

57. Signature of medical examiner

58. Signature of coroner

57. Signature of funeral director

58. Signature of health officer

59. Signature of registrar

58. Signature of informant

59. Signature of medical examiner

60. Signature of coroner

59. Signature of funeral director

60. Signature of health officer

61. Signature of registrar

60. Signature of informant

61. Signature of medical examiner

62. Signature of coroner

61. Signature of funeral director

62. Signature of health officer

63. Signature of registrar

62. Signature of informant

63. Signature of medical examiner

64. Signature of coroner

63. Signature of funeral director

64. Signature of health officer

65. Signature of registrar

64. Signature of informant

65. Signature of medical examiner

66. Signature of coroner

65. Signature of funeral director

66. Signature of health officer

67. Signature of registrar

66. Signature of informant

67. Signature of medical examiner

68. Signature of coroner

67. Signature of funeral director

68. Signature of health officer

69. Signature of registrar

68. Signature of informant

69. Signature of medical examiner

70. Signature of coroner

69. Signature of funeral director

70. Signature of health officer

71. Signature of registrar

70. Signature of informant

71. Signature of medical examiner

72. Signature of coroner

71. Signature of funeral director

72. Signature of health officer

73. Signature of registrar

72. Signature of informant

73. Signature of medical examiner

74. Signature of coroner

73. Signature of funeral director

74. Signature of health officer

75. Signature of registrar

74. Signature of informant

75. Signature of medical examiner

76. Signature of coroner

75. Signature of funeral director

76. Signature of health officer

77. Signature of registrar

76. Signature of informant

77. Signature of medical examiner

78. Signature of coroner

77. Signature of funeral director

78. Signature of health officer

79. Signature of registrar

78. Signature of informant

79. Signature of medical examiner

80. Signature of coroner

RECEIVED

BUREAU V. S.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

12455

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		STATE MARYLAND		COUNTY WASHINGTON			
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		LENGTH OF STAY (in this place) LIFE		CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 DUNN IRVIN DRIVE		STREET ADDRESS (If rural give location) 9 DUNN IRVIN DRIVE					
3. NAME OF DECEASED (First) EMMA (Middle) KATHRYN (Last) STAHL				4. DATE OF DEATH (Month) DEC. (Day) 30 (Year) 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (or other) MARRIED	8. DATE OF BIRTH 5/16/1881	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if HOUSEWIFE)		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SILAS WOLFENBERGER				14. MOTHER'S MAIDEN NAME EVALINE KUHN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NOME		17. INFORMANT & ADDRESS MRS. CALVIN HOFFMAN		HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease						13 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946, 19 to Dec-30, 1955, that I last saw the deceased alive on Dec-30, 1955, and that death occurred at 6:15 P.M. from the causes and on the date stated above. 12/31/55							
SIGNATURE <i>Kloyd A. Hoffman</i>				ADDRESS (Street, city, town, state) M.D. 214 N. Potomac St. Hagerstown, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/2/56		NAME OF CEMETERY OR CREMATORY SALEM REFORMED CHURCH		LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. REC'D BY REGISTRAR Jan. 3, 1956		REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A. J. Norment</i>		ADDRESS <i>Hagerstown, Md.</i>	

BUREAU V. S.

JAN 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12459

12492

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Clear Spring</u> LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Clear Spring, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>				STREET ADDRESS (If rural give location) <u>Near Clear Spring, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Cecil Paul Starliper</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 5 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 6, 1886</u>	
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Wash. Co. Md.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Railroad Engineer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>			
13. FATHER'S NAME: <u>Henry Starliper</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Mason Starliper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mrs Rubie Starliper</u>				210 Hager St. Hagerstown, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> Sudden							
ANTECEDENT CAUSE (B) <u>Previous Cerebral Hemorrhage</u> 5 yrs.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterial Sclerosis</u> 16 yrs.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION: <u>Jan 1953</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1953</u> to <u>Dec. 5, 1955</u> that I last saw the deceased alive on <u>Dec. 4, 1955</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David R. Brewer</u>		M. D.		ADDRESS <u>Clear Spring Md.</u>		DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/7/55</u>		REGISTRAR'S SIGNATURE <u>Joseph H. Murray</u>		24. FUNERAL DIRECTOR <u>Adrian H. Rowland</u>		ADDRESS <u>Clay, Md.</u>	

BUREAU V. S.

DEC 12 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12456

CERTIFICATE OF DEATH

12460

Reg. Dist. No. 302

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Washington	MARYLAND	STATE Maryland	COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	LENGTH OF STAY (in this place) 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Garlock Memorial Home		STREET ADDRESS (If rural give location) 721 West Washington Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) EDWARD (Middle) STANHOPE (Last) STARTZMAN		(Month) December (Day) 3 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH August 29, 1881
9. AGE last birthday 74 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Merchant		10b. KIND OF BUSINESS OR INDUSTRY Owned own Store	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amar Startzman		14. MOTHER'S MAIDEN NAME Anna White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 218-30-8983	
17. INFORMANT & ADDRESS Charles Startzman Hagerstown, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
421.4 IMMEDIATE CAUSE (A) acute broncho pneumonia			48 hrs
ANTECEDENT CAUSE(S) DUE TO (B) arterio sclerotic myocardial valvular heart disease			15 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ulcerative colitis			20 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION -	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? -			
22. I hereby certify that I attended the deceased from 7:46 , 19 37 , to Dec. 3 , 19 55 , that I last saw the deceased alive on Dec. 3 , 19 55 , and that death occurred at 6:35 P.M. from the causes and on the date stated above.			
SIGNATURE S. Robert Wells		DATE SIGNED 115 N. Potomac Street-Hagerstown, Md 12-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/6/1955	
NAME OF CEMETERY OR CREMATORY Rose Hill		LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. REC'D BY REGISTRAR DATE Dec. 5, 1955		REGISTRAR'S SIGNATURE PhasH Powers	
25. FUNERAL DIRECTOR'S SIGNATURE C. M. Suter & Sons		ADDRESS Hagerstown, Maryland	

CERTIFICATE OF DEATH

12100

Reg. Dist. No. 302

1. LEGAL REPRESENTATIVE (Name of Person)

NAME: [illegible] ADDRESS: [illegible]

DATE: [illegible]

AGE: [illegible] SEX: [illegible]

MARYLAND

COUNTY: [illegible]

DATE: [illegible]

NAME: [illegible]

ADDRESS: [illegible]

DATE: [illegible]

DATE: [illegible]

DATE: [illegible]

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DATE: [illegible]

DATE: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE: [illegible]

INTERMEDIATE CAUSE: [illegible]

DATE: [illegible]

BUREAU V. 1

DEC 21 1955

RECEIVED

DATE: [illegible]

DATE: [illegible]

12457

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN Hagerstown		50 years		TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital				STREET ADDRESS (If rural give location) 433 Elizabeth Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Lloyd Homer Stouffer				Dec 27 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	Dec. 21, 1893	62 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired, so state)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Night Watchman		Club		Fiddlersburg Md.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Frank Stouffer				Mary Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		214-09-2969		Mrs. Evelyn Stouffer Hag. Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pancreatitis, acute.						12-18 hrs	
ANTECEDENT CAUSE (S) Pneumonia of upper lobe						12-18 hrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Coronary sclerosis						Indefinite	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 2, 1954 to Dec 27, 1955 that I last saw the deceased alive on 12-26, 1955 , and that death occurred at 2A M, from the causes and on the date stated above.							
SIGNATURE Robert F. Keagle		M. D. Hagerstown		DATE SIGNED 12-28-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATOR		LOCATION (City, town, or county) (State)	
Burial		12-29-55		Rose Hill Cemetery		Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Dec. 29, 1955		REGISTRAR'S SIGNATURE Wash. Stouffer		24. FUNERAL DIRECTOR		ADDRESS	
				Scott F. Minnich & Son		Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AN 2 1956

RECEIVED

12433

CERTIFICATE OF DEATH

Reg. Dist. No. 3 D 6

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Smithburg</u>		<u>40 yrs.</u>		OR TOWN <u>Rural Smithburg</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>John Stull</u>				<u>12 29 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>1-1-1880</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>				<u>Penna.</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Harry Stull</u>				<u>Catherine Rock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			15. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
<u>no</u>					<u>Mrs. Henry Earley, Smithburg, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>48 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized Arteriosclerosis</u>						<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 28, 1955</u> to <u>Dec 29, 1955</u> , that I last saw the deceased alive on <u>Dec 29, 1955</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H G Kohler</u>				DATE SIGNED <u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>1-1-1956</u>		<u>Int. Zion Cemetery, Quincy, Pa.</u>	
24. FUNERAL DIRECTOR				ADDRESS			
<u>Geo W Ferguson</u>				<u>Gladhill Co., Middletown, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AN 2 1956

RECEIVED

12458

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>48 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>916 Salem Ave.</u>		STREET ADDRESS (If rural give location) <u>916 Salem Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES</u> <u>WALTER</u> <u>SULLIVAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 15</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 13, 1877</u>
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Yard Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Western Maryland R.R.</u>	11. BIRTHPLACE (State or foreign country): <u>Londenary Township, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Elijah Alexander Sullivan</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Hattie L. Sullivan Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>			<u>5-10 min</u>
ANTECEDENT CAUSE (B) <u>Coronary arteriosclerosis</u>			<u>Indef.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> to <u>12/15, 1955</u> , that I last saw the deceased alive on <u>12/15, 1955</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul Harrison MD</u>		ADDRESS <u>318 N. Potomac Hagerstown, Md.</u>	
DATE SIGNED <u>12/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/17/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>
LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Dec 16/1955</u>		REGISTRAR'S SIGNATURE <u>Phas H. Bowser</u>	
24. FUNERAL DIRECTOR <u>C. M. Suter & Sons</u>		ADDRESS <u>Hagerstown, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1955

BUREAU V. S.

12494

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Williamsport</u>		<u>15 yrs.</u>		TOWN <u>Williamsport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Md. Rfd #1</u>				STREET ADDRESS (If rural give location) <u>Williamsport Md. RFD #1</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<u>William Henry Taylor</u>		OF DEATH: <u>Dec. 26</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 20, 1890</u>	<u>65</u> yrs.	<u>3</u> Months	<u>6</u> Days	<u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Retd. Farmer</u>		<u>Farm</u>		<u>Williamsport Md. Rfd #1</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Allen Taylor</u>				<u>Martha Trone</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u> (If Yes, give war or dates of service) <u>No</u>		<u>219-12-0452</u>		<u>RFD #1</u> <u>Mr. Fred Taylor Williamsport Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE			(A)	<u>Cardiac Arrest</u>			<u>10 min.</u>
ANTECEDENT CAUSE (S)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B)	<u>Complete Heart block</u>			<u>6 months</u>
			DUE TO				
			(C)	<u>Arteriosclerotic Heart Disease</u>			<u>1 year</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>None</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County)	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>26 Dec.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>17 Dec.</u> , 19 <u>55</u> , and that death occurred at <u>5:15</u> PM, from the causes and of the date stated above.							
SIGNED		DATE SIGNED					
<u>W. Lee McElroy</u>		<u>27 Dec 55</u>					
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 29-55</u>		<u>Manor Cemetery</u>		<u>Near Tilghmanton Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 28-1955</u>		<u>W. Lee McElroy</u>		<u>Albert L. Leaf</u>		<u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 30 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

12465

2411 N. Charles Street, Baltimore

12459

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 2/ See: Birth Cert. et

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Williamsport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp</u>		STREET ADDRESS (If rural, give location) <u>41 W. Salisbury, St.</u>	
3. NAME OF DECEASED (First) <u>Jeffery</u> (Middle) <u>Allan</u> (Last) <u>Thomas</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-2-55</u> yrs. <u>8</u> months <u>35</u> min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Gerald Eugene Thomas</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Lee Hay</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>776X</u> Immediate cause (a) <u>Pneumonia</u> Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 MO</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (Specify) <u>While at Work</u> <input type="checkbox"/> <u>Not While at Work</u> <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2/55</u> , 19 <u>55</u> , to <u>12/3/55</u> , that I last saw the deceased alive on <u>12/3/55</u> , and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John P. Young</u>		ADDRESS <u>Williamsport Md</u>	
DATE SIGNED <u>12/4/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 6, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) <u>Williamsport</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 6, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. Bowers</u>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1955

BUREAU V. S.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12460 **CERTIFICATE OF DEATH**

12466

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
03 TOWN <u>Hagerstown, Md.</u>		31 yrs.		TOWN <u>Hagerstown Maryland</u>		03	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 422 N. Jonathan Street,				422 N. Jonathan Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
Minnie Jamima Weather				12 8 1955			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female		Colored		Married		Mar 10 1885	
						70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife		Own home		Baltimore Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Philip Brewer				Anna Frances			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Mrs Beatrice Lewis 422 N Jonathan			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				Cerebral Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Hypertension and Arteriosclerosis Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Diabetes mellitus			
260x (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3rd</u> , 19 <u>1941</u> , to <u>Dec 8th</u> , 19 <u>55</u> , that I last saw the deceased <u>Dec 7, 1955</u> , alive on <u>Dec 7, 1955</u> , and that death occurred at <u>7A</u> M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Philip J. Johnson</u>		<u>Hagerstown Md</u>		<u>12/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-11-1955		Queen Chapel Cemetery		Mirkirk, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>Dec 12, 1955</u>		<u>Charles H. Howard</u>		<u>John R. Watson Jr. Hagerstown Md</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12467

12435

CERTIFICATE OF DEATH

Reg. Dist. No.

304

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Hancock</u>		<u>Life</u>		TOWN <u>Rural Hancock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural give location) <u>Rural 2 Hancock Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Benjamin</u> (Middle) <u>Roy</u> (Last) <u>Weller</u>				(Month) <u>12</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9.30.1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hiram Weller</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Fritz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Ray Weller Hancock Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of the stomach</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>None</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15, 1955</u> , to <u>Dec. 20, 1955</u> , that I last saw the deceased alive on <u>Dec. 15, 1955</u> , and that death occurred at <u>12:40P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Pauli Robert Cohen</u> M.D.				ADDRESS (Street, city, town, state) <u>Clear Spring, Maryland</u>		DATE SIGNED <u>12/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12.23.55</u>		NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hancock Washington Maryland.</u>	
24. REC'D BY REGISTRAR <u>12/25/55</u>		REGISTRAR'S SIGNATURE <u>St. Keller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone Hancock Md</u>		ADDRESS	

304

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Off. No.

1. DATE OF DEATH

HANFORD

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BUREAU V. S.

DEC 29 1955

RECEIVED

Handwritten signature

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Brewer

12461

CERTIFICATE OF DEATH

12468

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>5 Mos</u>		OR TOWN <u>Hagerstown</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gateway Nursing Home</u>				STREET ADDRESS <u>905 Marion St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>GEORGE</u>		(Middle) <u>HENRY</u>		(Last) <u>WILES</u>		<u>Dec 2 1955</u> 19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)		
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>July 15 1874</u>	<u>81</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>		11. BIRTHPLACE (State or foreign country) <u>near Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Wiles</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>317-15-2819</u>		17. INFORMANT & ADDRESS <u>J. Frank Wiles</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A) <u>Cerebral Sclerosis</u>				<u>Arterial Sclerosis</u>		<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>						<u>10 yrs.</u>	
STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1955</u>, to <u>Dec. 2, 1955</u>, that I last saw the deceased alive on <u>Dec. 1, 1955</u>, and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Brewer</u> M.D.		ADDRESS (Street, city, town, State) <u>Clear Spring Md.</u>		DATE SIGNED <u>12/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. REC'D BY REGISTRAR <u>Dec 7-55</u>		REGISTRAR'S SIGNATURE <u>LeRoy M. Lockley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
				ADDRESS <u>Hagerstown Md.</u>			

(Deputy)

CERTIFICATE OF DEATH

ATTEST: REGISTERED DEATHS OF MARYLAND

MARYLAND

PLACE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 12, 1955		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		MANNER OF DEATH	
JANUARY 1, 1890		BALTIMORE, MARYLAND		NATURAL	
CAUSE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
HEART DISEASE		JAMES H. HARRIS			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 12, 1955		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		MANNER OF DEATH	
JANUARY 1, 1890		BALTIMORE, MARYLAND		NATURAL	
CAUSE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
HEART DISEASE		JAMES H. HARRIS			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

BUREAU V. S.

DEC 12 1955

RECEIVED

RECEIVED

12462

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Maryland	COUNTY Washington
CITY Hagerstown If outside corporate limits, write RURAL and give nearest town	LENGTH OF STAY 46 years in this place	CITY Hagerstown If outside corporate limits, write RURAL and give nearest town	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital	STREET ADDRESS 124 N. Locust St. If rural give location		
3. NAME OF DECEASED: (First) Anna (Middle) Volina (Last) Young		4. DATE (Month) Dec. (Day) 7 (Year) 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Jan. 29, 1887
9. AGE last birthday: 68 yrs.		10. IF UNDER 1 YEAR: Months 03 Days 1	11. IF UNDER 24 HRS. Hours 03 Min. 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now) Clark		10B. KIND OF BUSINESS OR INDUSTRY: Dept. Store	11. BIRTHPLACE (State or foreign country): Tanneytown Md.
13. FATHER'S NAME: John A. C. Baker		14. MOTHER'S MAIDEN NAME: Louise E. Wertz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No If Yes, give war or dates of service		16. SOCIAL SECURITY NO. 214-09-7370 A	
17. INFORMANT & ADDRESS: Mrs. Andrew F. Ridenour Rt. 1		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Hypertensive arterio sclerotic		7 yrs	
ANTECEDENT CAUSE (S) myocardial heart disease with failure grade iv			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arterio sclerotic coronary heart disease		3 yrs.	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: -	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) Jan. '40	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. '40 to 12-7, 1955 , that I last saw the deceased alive on 12-7, 1955 , and that death occurred at M. from the causes and on the date stated above.			
SIGNATURE S. R. M. D.		DATE SIGNED Dec. 9-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-10-55	
NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		LOCATION (City, town, or county) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Dec. 9, 1955		24. FUNERAL DIRECTOR Scott F. Minnich & Son	
REGISTRAR'S SIGNATURE Chas. H. Bowers		ADDRESS Hag. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Robt Campbell

12470

12463

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 16, Film G190 12-13-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>3 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		<u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>149 Alexander St.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>ROWLAND STEELMAN YOURISON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 5 1955 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 21 1923</u>	9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dis trict Manager News Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph S. Yourison</u>				14. MOTHER'S MAIDEN NAME <u>Hazel n Steelman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. # 2 227-18-5066</u>		17. INFORMANT & ADDRESS <u>Mrs Irene Yourison</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
190X IMMEDIATE CAUSE (A) <u>malignant melanoma</u>						<u>4 mos</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1/8/16/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Propry gland nck - malig. melanoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, inn, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/15</u> , 19 <u>55</u> , to <u>12/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert V h Campbell MD</u>		ADDRESS (Street, city, town, state) <u>145 W Wash. St Hagerstown Md</u>		DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Richmond ? Virginia</u>	
24. REC'D BY REGISTRAR <u>Dec 7 1955</u>		REGISTRAR'S SIGNATURE <u>Charles H Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown Md.</u>			

CERTIFICATE OF DEATH

Local Date No.

DEATH RECORDING BOARD OF BALTIMORE

PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 COLOR

CAUSE OF DEATH
 IMEDIATE
 REMOTE

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR

DATE OF REGISTRATION
 TIME OF REGISTRATION
 PLACE OF REGISTRATION

NAME OF REGISTRAR
 SIGNATURE OF REGISTRAR

DATE OF REGISTRATION
 TIME OF REGISTRATION
 PLACE OF REGISTRATION

NAME OF REGISTRAR
 SIGNATURE OF REGISTRAR

BUREAU V. 8

DEC 9 1955

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1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other qualified person to fill out this certificate truthfully and accurately. It is the duty of the registrar to receive and file this certificate, and to issue a death certificate to the family of the deceased. The death certificate is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the registrar to issue a death certificate truthfully and accurately. The death certificate is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the registrar to issue a death certificate truthfully and accurately.